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

Model Language to Assist Employers in Improving Access to Mental Health and Substance Use Care for Plan Members

This document provides Model Language regarding specific actions that employers can take to improve access to behavioral health care for employees and their dependents with mental health and substance use disorders ("MH/SUDs"). The goals of these actions are to help employers (1) improve the behavioral health of their plan members and (2) generate a positive ROI by reducing total healthcare costs[1], presenteeism, and absenteeism. The use of clear and consistent language communicates the employer's goals and expectations in the most effective way to drive the urgently needed improvements in MH/SUD care.

The Model Language was developed by The Path Forward for Mental Health and Substance Use ("PF"), an employer-led initiative to improve access and quality in MH/SUD care by implementing four well proven, achievable reforms:

1) Increase access to in-network MH/SUD providers;

2) Expand implementation of the Collaborative Care Model (CoCM) in primary care settings;

3) Expand screening for and monitoring of MH/SUDs through measurement-based care (MBC); and

4) Sustain expanded access to tele-behavioral health services.

The Model Language requests information from TPAs regarding their performance and capabilities in these four areas. These requests are primarily for analyses of claims and administrative data conducted by the TPA. **Employers and benefits consultants do not need to conduct any of these analyses**.

As an essential step to advance implementation of these reforms, we recommend that employers and their benefits consultants use the Model Language, in conjunction with the data templates embedded as links, when (a) amending or negotiating contracts with TPAs and providers, (b) developing RFPs (which, to be effective, must assign a high "score" (i.e., weighting) to responses related to the reforms addressed in the Model Language), and (c) communicating the employer's goals and expectations.

An employer may choose to use only certain sections of the Model Language, depending on the TPA's current performance or the employer's specific priorities.

[1] A recent Milliman study demonstrates that medical costs are 3 – 6 times higher for individuals who also have behavioral health conditions than for those who do not. How do individuals with behavioral health conditions contribute to physical and total healthcare spending? (milliman.com)

However, we urge that all the action steps set forth in the Model Language be taken over time.

The Model Language has been reviewed by employer coalitions, benefit consultants, HR policy organizations, providers and leading behavioral health experts. **Updated versions** of the Model Language will be available at: (link).

The data templates linked to the Model Language are provided in an Excel Workbook ("Workbook") to ensure that TPAs provide detailed, precise and consistent information, which is essential to enabling employers and their benefits consultants to measure improvements in MH/SUD care delivery. A Summary Tab in the Workbook provides employers and their benefits consultants with brief overview data indicating whether a TPA is performing in a manner that supports implementation of the key actions requested.

Some data sets, depending upon the responses provided, require a "Plan of Correction." An employer may also consider requiring performance guarantees with respect to data sets that indicate significant access problems.

In summary: Employers are aware that the urgency to improve access to MH/SUD care existed well before the COVID-19 pandemic, but escalated further with the surge in MH/SUDs attributable to the pandemic and related economic downturn and societal stressors. Use of the Model Language and Workbook is the most effective way to achieve significant improvements.

The following Appendices are attached:

Appendix A is an "Example Report Card" reflecting the type of information employers can expect to receive from their TPAs by requiring use of the Workbook.

Appendix B is the actual Model Language for use in amending or negotiating contracts with TPAs and preparing RFPs (with embedded links to the Workbook).

Appendix C is a description of the metrics used in the Model Language and the rationale for the use of these metrics.

Appendix D is the actual Workbook to be sent to and completed by TPAs.

Please note:

(1) The Model Language for TPA Contracts and RFPs is in the public domain, so employers and benefits consultants may adapt the language to suit their respective needs and use their own branding as they deem appropriate;

(2) When sending the Model Language to TPAs, it is important to identify which "Specified Plans" and which "Specified Regions" are to be the subject of the data requests. Generally, the Specified Regions should be areas where the employer has large concentrations of employees**.**

APPENDIX A – EXAMPLE REPORT CARD

This Appendix A is an "Example Report Card" illustrating how information obtained by using the "Model Language for TPA Contracts and RFPs" and the companion Workbook can help an employer target specific area for TPA improvement with respect to MH/SUD care access and quality. The **latest version** of this document is at: link

The Model Language primarily requests that a TPA analyze claims and administrative data which are commonly tracked in **four areas** related to the adequacy of MH/SUD care provided in the TPA's network:

1. **Access to In-network (INN) MH/SUD Providers**
2. Implementation of the **Collaborative Care Model** (CoCM) in Primary Care Settings
3. Screening for and Monitoring of MH/SUD with **Measurement-Based Care** (MBC)
4. Access to **Tele-Behavioral Health** ("TBH") Services

In a few areas, the TPA is asked to describe or enhance its current outreach efforts to providers.

A TPA's responses to these data and outreach requests allow the employer to evaluate a TPA's current capability to support the employer's goals. When performance standards outlined in the Model Language data Workbook are not met, a Plan of Correction is required.

Goals	Key Measures	Sample Data Revealed in the data request workbook	Improvement Required
Access to In-Network (INN) MH/SUD providers that is comparable to access to INN M/S providers	Use of Out-of-Network (OON) MH/SUD providers vs. M/S providers	OON MH/SUD providers are used 3.5 times more than OON M/S providers	Reduction in OON use for MH/SUD providers
	Reimbursement rates for INN MH/SUD providers relative to M/S providers for the same or comparable CPT codes	INN MH/SUD providers are reimbursed 24% less than INN M/S providers	Increase in INN reimbursement rates for MH/SUD providers to a level at least equal to M/S provider rates, or higher if OON use for MH/SUD providers remains higher than for M/S providers

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	Difficulties that members face when seeking care for the first time from an INN provider	Members seeking a new MH/SUD provider receive no treatment twice as often as members seeking a new M/S provider because they cannot find an INN MH/SUD provider, and when they do, "search times" to find a provider and "wait times" for an appointment are weeks longer than for M/S providers.	Increase the number of INN MH/SUD providers who offer timely appointments to new members seeking care
	Availability of psychiatrists listed in TPA's network directory	40% of psychiatrists listed in TPA's network directory submitted claims for zero plan members during the plan year	Increase accuracy of network directory and the number of "available" INN psychiatrists, if use of OON MH/SUD providers remains higher than use of OON M/S providers
Rapid CoCM Implementation so that most MH/SUD patients can be effectively treated by their PCPs or other CoCM-eligible providers	Volume of claims submitted during a plan year using CoCM billing codes	1200	Volume increase of 20% or more each year
	CoCM reimbursement rates as compared to rates for common E/M codes used by PCPs (each indexed to Medicare reimbursement rate as the benchmark)	CoCM reimbursement rates are 30% less than rates for common E/M codes used by PCPs (each indexed to Medicare reimbursement rate as the benchmark)	Increase rates for CoCM codes to be equivalent to rates for common E/M codes used by PCPs (each indexed to Medicare reimbursement rate as the benchmark)

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	Technical assistance (TA), training and/or financial support provided by TPA to PCPs to implement CoCM	None undertaken	Plan with concrete action steps toward providing TA, training and financial support for CoCM
Measurement Based Care (MBC)	HEDIS Depression measures required of commercial ACOs	None reported	Implementation of reporting on HEDIS Depression measures by commercial ACOs
	Evidence of endorsement of MBC by TPA	None undertaken	Active endorsement of MBC, including letters to The Joint Commission, URAC, and other accrediting entities
Tele-Behavioral Health (TBH)	Audio-only TBH reimbursement	Currently reimbursing	Sustain
	Reimbursement rates for audio-only TBH, audio-video TBH and in-person office visits	Equivalency in reimbursements for audio-video TBH and in-person office visits, but lower reimbursement for audio-only TBH.	Increase audio-only TBH reimbursements to be equivalent to reimbursement for audio-video TBH and in-person office visits.

APPENDIX "B"
Model Language for TPA Contracts and RFPs

The Model Language requests specific data and member/provider outreach activity from a TPA in **four commonly tracked areas** relating to the adequacy of MH/SUD care provided within a TPA's network:

1. **Access to In-network (INN) MH/SUD Providers** – data reporting in five areas reflecting or impacting adequacy of INN access. One of these five (ease and timeliness of access) is to be validated via member survey;

2. Implementation of the **Collaborative Care Model** (CoCM) in Primary Care Settings – data reporting in two areas, benefit design barriers and demonstration of expanded outreach and support to providers;

3. Screening for and monitoring of MH/SUD conditions using **Measurement-Based Care** (MBC) – evidence of active support for MBC and promotion of its expansion among network providers, and data reporting in one area;

4. Access to **Tele-Behavioral Health** ("TBH") Services – information related to coverage and reimbursement of TBH services, and data reporting on volume of TBH claims.

Within each of these four areas, Plans of Correction may be warranted based on the information provided by the TPA.

No data analyses are required of the employer or the benefits consultant.

The Model Language and the Companion Workbook may be used when (a) amending or negotiating contracts with TPAs and providers, (b) developing RFPs, and (c) simply communicating clients' goals and expectations regarding a TPA's ability to ensure timely access to quality in-network MH/SUD care for employees and their dependents.

NOTE: This Model Language for TPA Contracts and RFPs will be updated periodically. Please check the following link for the current version: Model Contract/RFP Language for Implementation of The Path Forward Reforms [embed link].

MODEL LANGUAGE BEGINS ON THE FOLLOWING PAGE

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MODEL LANGUAGE BEGINS HERE

[Employer] seeks information that demonstrates [TPA's] support of its goal to ensure that members with MH/SUDs can obtain timely access to affordable and effective care. [Employer] has identified four priority areas that it believes offer opportunities to positively impact care access and quality. These areas are set forth below in Sections 1 - 4, with information requested from [TPA] regarding each. Links to an Excel Workbook are provided under each Section that detail the specific data requirements and, when warranted, Plans of Correction. One Workbook should be completed for each plan in each region previously identified by [Employer] ("Specified Plans" and "Specified Regions").

Definitions of certain terms used below are provided at the end of this document.

1. Increase Access to In-network (INN) MH/SUD Providers

[Employer] seeks to ensure that **[**TPA's**]** provider network includes sufficient numbers and availability of MH/SUD providers so that members seeking care for MH/SUDs can obtain timely appointments and effective treatment with In-network (INN) providers. To evaluate whether [TPA's] provider network adequately supports this goal, [Employer] requests [TPA] to provide the data and information described under items (a) through (e) below using the Workbook (***details regarding reporting methodology and format are set forth in the highlighted links associated with each data request***).

[TPA] agrees to provide:

(a) Out-of-Network Use (OON): For plans that provide OON benefits, data regarding OON use for MH/SUD providers as compared to M/S providers (link to Workbook, Tab 1(a));

(b) Network Adequacy and Participation for Psychiatrists: Data regarding network adequacy and network participation for psychiatrists (link to Workbook, Tab 1(b));

(c) In-network Reimbursement Rates: Data regarding INN reimbursement rates for specified office visit CPT codes for MH/SUD providers as compared to M/S providers (link Workbook, Tabs 1(c)(i), 1(c)(ii));

(d) MH/SUD Professional Provider and Facility Admission to Network: Data regarding average time frames for admission to [TPA's] network for MH/SUD providers and facilities as compared to M/S providers and facilities (link to Workbook, Tab 1(d)).

(e) Ease and Timeliness of Access to In-network Providers: A description of [TPA's] quantitative standards for new patient "search times" and "wait times" for INN MH/SUD providers as compared to INN M/S providers and survey mechanisms for validating compliance with such standards (link to Workbook, Tab 1(e)).

2. Expand Implementation of the Collaborative Care Model (CoCM) in Primary Care Settings

[Employer] seeks to ensure that [TPA] actively promotes and incentivizes effective treatment of MH/SUD by primary care providers in its network through expanded implementation of the Collaborative Care Model (CoCM). CoCM increases access to MH/SUD care by integrating this care into the primary care setting.

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To evaluate whether [TPA] supports [Employer's] desire for expanded implementation of CoCM by PCPs in [TPA's] provider network, [Employer] requests the data described under items (a) through (c) below (***details regarding reporting methodology and format are provided in the highlighted links associated with each data request***).

[TPA] agrees to provide:

(a) Volume of Allowed CoCM Claims: Data regarding volume and year over year growth rates in volume of allowed CoCM claims submitted, as well as volume of unique members for whom CoCM billing is submitted (link to Workbook, Tab 2(a)).

(b) In-network Provider Reimbursement for CoCM and Out-of-Pocket Cost to Members: Data regarding CoCM provider reimbursement rates, limits on CoCM billing frequency and member out-of-pocket costs for CoCM CPT codes (link to Workbook, Tabs 2(b)(i), 2(b)(ii)).

(c) Provider Outreach, Training and Support: (i) Information and data regarding [TPA's] promotion of CoCM among PCPs and other CoCM-eligible clinicians in [TPA's] network, and (ii) provision of training and technical support grants (link to Workbook Tabs 2(c)(i), 2(c)(ii)).

3. Expand Screening for and Monitoring of MH/SUD with Measurement-Based Care (MBC)

[Employer] seeks to ensure that quality outcomes measurement and accountability are embedded in the delivery of MH/SUD care through expanded use of Measurement Based Care (MBC) within its provider network. All [TPA] providers treating MH/SUDs (including primary care and MH/SUD specialty providers) should be encouraged and incentivized to implement MBC.

To assist [Employer] in evaluating the use of MBC within [TPA's] provider network, [Employer] is requesting the data described under items (a) through (c) below (***details regarding reporting methodology and format are provided in the highlighted links associated with each data request)***.

[TPA] agrees to provide:

(a) HEDIS Reporting: Documentation of adherence to the requirement for participating commercial Accountable Care Organizations (ACOs) and other providers participating in [TPA's] network under value-based contracting arrangements, to report at least 2 HEDIS data measurements on effectiveness of care (these quality measures are already in use by Medicare ACOs) (link to Workbook, Tab 3(a)).

(b) Demonstration of Active Support for MBC: Documentation of written public support for the use of MBC for MH/SUD services to URAC, The Joint Commission, NCQA and CARF (link to Workbook, Tab 3(b)).

(c) Promotion of MBC in the treatment of MH/SUDs: Verification of promotion with all network MH/SUD and M/S providers the need for MBC tools for diagnosing and treating MH/SUDs, such as the PHQ-9, GAD-7 and related validated tools (link to Workbook, Tab 3(c)).

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4. Sustain Expanded Access to Tele-Behavioral Health ("TBH") Services

[Employer] seeks to ensure that the increase in access to tele-behavioral health (TBH) services due, in part, to TPAs reimbursing for audio-only sessions (in addition to audio-video sessions) at rates comparable to in-person office visits, is sustained. [Employer] also seeks to verify standards to ensure quality in TBH care delivery.

To assess [TPA's] commitment to sustaining expanded access to TBH for MH/SUDs, [Employer] is requesting data and information described under items (a) and (b) below (***details regarding reporting methodology and format are provided in the highlighted links associated with each data request***).

[TPA] agrees to provide:

(a) TBH Coverage and Reimbursement: Verification that MH/SUD providers are reimbursed for both audio-only and audio-video treatment modalities for TBH services AND that the allowed amounts for such services are the same as the allowed amounts for in-person office visits (link to Workbook, Tab 4(a)).

(b) Data Reporting related to: (i)TBH spending and allowed claims volume by modality for INN and OON; (ii) INN reimbursement information and allowed amounts reimbursed for high-volume TBH codes, by modality; and (iii) use of MBC among [TPA's] third party TBH providers (link to Workbook, Tab 4(b)).

Definitions:

1. **Collaborative Care Model (CoCM):** The evidence-based integrated care model for PCP and other medical settings as specifically set forth in CPT codes 99492, 99493, 99494, 99484, and GCLO1 and HCPCS code G2214. This BH care delivery approach allows care to be delivered by a PCP or other eligible clinician who is supported by a BH care manager (virtually or in-person) and a consulting psychiatrist (virtually). See American Psychiatric Association Foundation's Center for Workplace Mental Health CoCM Infographic, http://workplacementalhealth.org/getmedia/c3dd426a-dc06-44a7-9d4a-dc6b3f90fbf8/Collaborate-Print

2. **Inpatient facility:** (a) A hospital, non-hospital-based facility or residential treatment facility, including all medical and surgical admission to general acute care hospitals, long-term acute care hospitals, inpatient rehabilitation facilities, and skilled nursing facilities and (b) all mental health/substance use disorder (MH/SUD) admissions to psychiatric hospitals, general acute care hospitals, non-hospital based inpatient facilities, and residential treatment facilities.

3. **Measurement-Based Care (MBC):** The systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient in order to optimize the efficiency, accuracy and consistency of symptom assessment and to maximize the likelihood that nonresponse to treatment is detected by the provider. See, A Tipping Point for Measurement-Base Care**,** J. Fortney, Ph.D., J. Unützer, M.D., M.P.H., G. Wrenn, M.D., M.S.H.P., J. M. Pyne, M.D., G. R., M.D., M. Schoenbaum, Ph.D., H.T. Harbin, M.D., published online Sept. 2016.

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4. **Member:** Insured subscriber and any dependents insured under the employer group health plan.
5. **Office visit:** A non-facility-based medical/surgical (PCP only) or MH/SUD office visit.
6. **Outpatient facility:** (a) physical, occupational, speech and cardiovascular therapy, surgeries, radiology, pathology, and pharmacy service for medical or surgical care provided in an outpatient facility setting; and (b) intensive outpatient and partial hospitalization services for MH/SUD conditions in an outpatient facility setting.
7. **Primary care providers (PCPs):** General practice, family practice, internal medicine, and pediatric medicine physicians.
8. **Psychiatrists:** Includes child psychiatrists.

APPENDIX "C"
Description and Rationale for Metrics Required by The Model Language for TPA Contracts and RFPs

This Appendix "C" provides a description of and the rationale for the data and information metrics requested of TPAs in the Model Language for TPA Contracts and RFPs. These data metrics will enable employers to evaluate the access to timely, affordable and effective care for mental health and substance use disorders (MH/SUDs) provided by their health plans. The **latest version** of this document is at: link

1. Increase Access to In-network (INN) MH/SUD Providers

It is vital to ensure that TPA's provider network includes sufficient numbers and availability of MH/SUD providers so that members seeking care for MH/SUDs can obtain timely appointments and effective treatment with In-network (INN) providers. Data on the metrics outlined in (a) – (e) below will facilitate the employer's goal of eliminating:

(i) long "search times" to find and secure appointments with INN providers,
(ii) long "wait times" for appointments,
(iii) high copays/co-insurance costs for members who see out-of-network (ONN) providers because they cannot find, or wait long enough to see, INN providers, and
(iv) members foregoing care because they cannot afford the out-of-pocket costs associated with OON care.

(a) Out-of-Network Use (OON): For plans that provide OON benefits, data regarding OON use for MH/SUD providers as compared to M/S providers is an indicator of access to MH/SUD care. Member out-of-pocket costs are typically higher when they obtain care from ONN providers. OON provider use is often the result of an inability to gain timely access to INN providers. Actuarial studies of national and state data demonstrate that OON provider use is typically much higher for MH/SUD care than for medical/surgical (M/S) care.[1] This indicates that MH/SUD providers are available, but many are not INN.

(b) Network Adequacy and Participation for Psychiatrists: Assessment of network adequacy for psychiatrists should not be based solely on the number of such providers listed in the network directory. It is important to understand how many listed providers are in fact seeing members covered under a TPA's benefit plans. If a significant percentage of listed providers are billing for few or no members, it is likely that, even though they are listed in the network directory, they are not actually available for members seeking care.

(c) In-network Reimbursement Rates: Data regarding INN reimbursement rates for specified office visit CPT codes for MH/SUD providers as compared to M/S providers is very helpful in identifying barriers to network participation. Reimbursement rates that are perceived as inadequate are an

[1] *Addiction and mental health vs. physical health: Analyzing disparities in network use and provider reimbursement rates,* published Dec. 2017, http://www.milliman.com/NQTLDisparityAnalysis/
Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement rates, published Nov. 2019, https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p

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impediment to any provider's ability and willingness to join TPA networks. Reimbursement rate disparities between MH/SUD and M/S providers are important to consider when examining MH/SUD network adequacy, and should be examined in relation to the relative levels of OON utilization. The goal is not to simply establish reimbursement equivalency for MH/SUD and M/S providers. If OON use in certain regions is materially higher for MH/SUD providers (as is often the case), increasing reimbursement for MH/SUD providers above equivalency may be a necessary step to take in these regions.

In fact, many employers have effectively increased reimbursement rates significantly for some MH/SUD providers by contracting with Lyra or similar firms to supplement their TPAs' MH/SUD networks. They see this as a necessary step to compensate for limited MH/SUD provider participation in TPA networks due to disincentives such as inadequate in-network reimbursement and uncompensated administrative requirements such as utilization review.

(d) MH/SUD Professional Provider and Facility Admission to Network: Data regarding average time frames for admission to a TPA's network for MH/SUD providers and facilities as compared to M/S providers and facilities is also important in identifying barriers to network participation. Lengthy time frames associated with joining networks serve as another impediment to establishing an adequate MH/SUD provider network. Time frames should be efficient in order to encourage MH/SUD provider participation. The time it takes on average for a MH/SUD provider or facility to be admitted to a TPA's network after submitting an application should be no more than the time it takes on average for admission of a M/S provider or facility to a TPA's network

(e) Ease and Timeliness of Access to In-network Providers for MH/SUD Care: Delays in finding and scheduling appointments with an INN provider lead to increased OON utilization, with higher out-of-pocket costs for those members obtaining OON care, and no care at all for members foregoing treatment because they cannot afford the out-of-pocket costs. TPAs should have "search time" (the time it takes to find an INN provider) standards for new patients and "wait time" (the time it takes to obtain an appointment) standards for new patients that are equivalent for both INN MH/SUD providers and INN M/S providers. TPAs should also have survey mechanisms for validating compliance with such standards. This is intended to ensure ease and timeliness of access to INN MH/SUD providers for new patients for both routine and urgent appointments. Thus, a description of the quantitative standards for new patient "search times" and "wait times" for INN MH/SUD as compared to INN M/S providers, and survey mechanisms for validating compliance with such standards are requested.

2. Expand Implementation of the Collaborative Care Model (CoCM) in Primary Care Settings

The metrics requested below in (a) – (c) will assist employer in ensuring that its TPA actively promotes and incentivizes effective treatment of MH/SUD by primary care providers in its network through expanded implementation of the Collaborative Care Model (CoCM). CoCM increases access to MH/SUD care by integrating this care into the primary care setting. CoCM is the only evidence-based, highly-scalable approach to improving MH/SUD care provided by Primary Care Providers (PCPs), who treat the

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majority of MH/SUD patients. More than 70 randomized controlled trials and years of experience have demonstrated that CoCM improves mental health outcomes and reduces total healthcare costs.[2]

Expanded CoCM implementation, leveraging the strength of the primary care system to deliver high quality MH/SUD care for patients with mild/moderate conditions, supports an employer's goal of eliminating long "search times" and "wait times" for INN appointments with MH/SUD providers, higher out-of-pocket costs for members who see ONN MH/SUD providers because they cannot find INN providers, and members receiving no care when they cannot afford ONN MH/SUD treatment.

(a) Volume of Allowed CoCM Claims: Given the ability of CoCM to increase access to MH/SUD care for members, expansion of this model is critical. To determine the extent to which a TPA is reimbursing for CoCM use among PCPs in the TPA's network, and employer should examine the volume of allowed CoCM claims, growth in volume, and the number of unique members for whom these claims are being submitted.

(b) In-network Provider Reimbursement for CoCM and Out-of-Pocket Cost to Members: As with MH/SUD specialty providers, unnecessary restrictions imposed on billing frequency and inadequate reimbursement rates for PCPs and other eligible clinicians for CoCM services are an impediment to a provider's ability and willingness to optimally deliver these services to members. Similarly, to encourage members to obtain MH/SUD care under CoCM, TPAs should ensure that out-of-pocket costs to members are waived.

(c) Provider Training and Support: TPAs' actively promoting and facilitating CoCM implementation among PCPs in TPA's network is key to increasing member access to MH/SUD care through CoCM. Provider awareness of CoCM and TPA's reimbursement for CoCM codes, as well as financial incentives for CoCM implementation, training and support activities, are critical determinants of successful implementation. Information and data evidencing TPA's promotion of CoCM among PCPs and other CoCM eligible clinicians in TPA's network, and provision of training and technical support grants is vital toward achieving this goal.

3. Expand Screening for and Monitoring of MH/SUD Through Measurement-Based Care (MBC)

The standardization and widespread implementation of Measurement Based Care (MBC) is a crucial next step for integrated primary care. MBC refers to the systematic administration of standardized, validated symptom rating scales to monitor treatment progress, assess outcomes, and guide treatment decisions, from initial screening to completion of care. Studies have demonstrated that consistent use of validated symptom measurement tools improves treatment outcomes by 20% – 60% and generates a nearly 75% difference in remission rates between patients receiving MBC and those receiving usual care.[3]

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[2] See American Psychiatric Association Foundation's Center for Workplace Mental Health CoCM Infographic, http://workplacementalhealth.org/getmedia/c3dd426a-dc06-44a7-9d4a-dc6b3f90fbf8/Collaborate-Print

[3] A Tipping Point for Measurement-Base Care, J. Fortney, Ph.D., J. Unützer, M.D., M.P.H., G. Wrenn, M.D., M.S.H.P., J. M. Pyne, M.D., G. R., M.D., M. Schoenbaum, Ph.D., H.T. Harbin, M.D., published online Sept. 2016.

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The metrics provided below in (a) – (c) will help employer to ensure that quality outcomes measurement and accountability are embedded in the delivery of MH/SUD care through expanded use of MBC within a TPA's provider network. All TPAs and providers treating MH/SUDs (including primary care and MH/SUD specialty providers) should be encouraged and incentivized to implement MBC.

(a) HEDIS Reporting: To encourage expansion of MBC within a TPA's network, at minimum, Accountable Care Organizations (ACOs) and other providers contracted by a TPA under value-based arrangements should currently be reporting HEDIS data measurements already in use by Medicare ACOs related to the effectiveness of depression care. This metric will verify whether TPAs are doing so.

(b) Demonstration of Active Support for MBC: Support from TPAs for major accrediting organizations to require MBC in the treatment of MH/SUD can be instrumental in furthering momentum already underway within these organizations to strengthen such requirements. Documentation of written public support for the use of MBC with organizations such as URAC, The Joint Commission, NCQA and CARF, will effectuate this goal.

(c) Promotion of MBC in the treatment of MH/SUDs: Expansion of MBC can be accelerated by TPAs promoting the need for MH/SUD and M/S providers to consistently use MBC for diagnosing and treating MH/SUDs. Documentation evidencing TPA's promotion of MBC diagnostic and treatment validating tools ensures TPA accountability in this regard.

4. Sustain Expanded Access to Tele-Behavioral Health ("TBH") Services: Tele-behavioral health ("TBH") – virtual access to MH/SUD care – has grown dramatically since the onset of COVID-19, in part because TPAs are reimbursing for audio-only sessions (in addition to audio-video sessions) at rates comparable to in-person sessions. This is a significant step forward in expanding access to INN care for MH/SUDs. The metrics set forth in (a) – (c) below help to ensure that this increase in access is sustained, in conjunction with the assurance of quality in TBH care delivery.

(a) TBH Coverage and Reimbursement: TPA should provide equivalent reimbursement to MH/SUD providers for audio-only, audio-video and face-to-face modalities of treatment. It should not be assumed that every health plan member owns a laptop or smartphone, or that the device used is not shared. Evidence supports the effectiveness of both audio-only and audio-video TBH.[4] TPAs should verify that allowed amounts for these three treatment modalities are the same.

(b) Data Reporting related to TBH: Maintaining and expanding greater access to MH/SUD care through TBH is critical to sustain the gains driven largely by COVID-19. It is important for employers to understand the TBH modalities covered by their TPA(s), whether reimbursement across modalities supports member choice of modalities, and how quality is monitored and maintained in the provision of TBH by providers in TPA's network. Data on volume of allowed claims by modality,

[4] Varker T, Brand RM, Ward J, Terhaag S, Phelps A. Efficacy of synchronous telepsychology interventions for people with anxiety, depression, posttraumatic stress disorder, and adjustment disorder: A rapid evidence assessment. Psychological services. 2019 Nov;16(4):621

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allowed amounts for high-volume TBH codes and use of MBC among TPA's third party TBH providers are important data sets for TPA accountability in achieving this goal.

Definitions:

1. **Collaborative Care Model (CoCM):** The evidence-based integrated care model for PCP and other medical settings as specifically set forth in CPT codes 99492, 99493, 99494, 99484, and GCLO1 and HCPCS code G2214. This BH care delivery approach allows care to be delivered by a PCP or other eligible clinician who is supported by a BH care manager (virtually or in-person) and a consulting psychiatrist (virtually). See American Psychiatric Association Foundation's Center for Workplace Mental Health CoCM Infographic, http://workplacementalhealth.org/getmedia/c3dd426a-dc06-44a7-9d4a-dc6b3f90fbf8/Collaborate-Print
2. **Inpatient facility:** (a) A hospital, non-hospital-based facility or residential treatment facility, including all medical and surgical admission to general acute care hospitals, long-term acute care hospitals, inpatient rehabilitation facilities, and skilled nursing facilities and (b) all mental health/substance use disorder (MH/SUD) admissions to psychiatric hospitals, general acute care hospitals, non-hospital based inpatient facilities, and residential treatment facilities.
3. **Measurement-Based Care (MBC):** The systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient in order to optimize the efficiency, accuracy and consistency of symptom assessment and to maximize the likelihood that nonresponse to treatment is detected by the provider. See, A Tipping Point for Measurement-Base Care**,** J. Fortney, Ph.D., J. Unützer, M.D., M.P.H., G. Wrenn, M.D., M.S.H.P., J. M. Pyne, M.D., G. R., M.D., M. Schoenbaum, Ph.D., H.T. Harbin, M.D., published online Sept. 2016.
4. **Member:** Insured subscriber and any dependents insured under the employer group health plan.
5. **Office visit:** A non-facility-based medical/surgical (PCP only) or MH/SUD office visit.
6. **Outpatient facility:** (a) physical, occupational, speech and cardiovascular therapy, surgeries, radiology, pathology, and pharmacy service for medical or surgical care provided in an outpatient facility setting; and (b) intensive outpatient and partial hospitalization services for MH/SUD conditions in an outpatient facility setting.
7. **Primary care providers (PCPs):** General practice, family practice, internal medicine, and pediatric medicine physicians.
8. **Psychiatrists:** Includes child psychiatrists.

One Specified Plan in One Specified Region

Instructions
Template Model Language Excel Workbook

(1) The **most recent version** of (a) the template Model Language, and (b) this "One Specified Plan/One Specified Region" Workbook can be found at: [[NEED LINK]]

(2) Each year, your client or your client's benefits consultant will provide a list of "Specified Plans" and "Specified Regions". Generally, the Specified Regions will be areas where the client has large concentrations of employees. If you have not received a list, please ask for one.

(3) **Complete one copy of this Workbook each year for each Specified Plan in each Specified Region.**

For example, if there are 2 Specified Plans which are each in 3 Specified Regions, then complete 6 copies of this Workbook.

The file name of each Workbook should indicate the Specified Plan and Specified Region addressed in the Workbook.

(4) Throughout this workbook, insert data **only** in cells that are highlighted **yellow**. The remainder of the cells should auto-fill as a result of the data that you inserted into the yellow cells.

(5) Insert:

Name of TPA:		**Specified Plan:**	
Plan Year:		**Specified Region:**	

Does the Specified Plan have Out-of-Network benefits (as defined below)? (Yes, No)

(6) For each Workbook, review the Summary tab **after** you have completed all the other tabs. The Summary tab will "auto-fill" with data from the other tabs.

(7) If you feel that any data are inconsistent (e.g., the formula creating the auto-fill information is incorrect), please send an email detailing the identified issue to: ModelLanguageHelpDesk@gmail.com [[CREATE EMAIL]]

Questions can be sent to the same email address.

(8) Each section of the Workbook includes instructions as to the circumstances under which the data indicates that a “Plan of Correction” is required and what each such plan should encompass.

(9) Any required Plans of Correction and all Workbooks should be provided by April 30 of each year, covering the prior year.

(10) CPT Codes referenced:

99213 Evaluation and management of an established patient in an office or outpatient location for 15 minutes

99214	Office/other OP visit for eval & mgmt of established patient; requires (2+): detailed history, detailed examination, medical decision-making of moderate complexity
90834	Psychotherapy 45 minutes
90837	Psychotherapy 45 minutes
99492	Initial psychiatric collaborative care management, first 70 minutes in first month
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month
99484	General BH Integration - At least 20 minutes per calendar month

(11) **Definitions:**

Collaborative Care Model (CoCM): The evidence-based integrated care model for PCP and other medical settings as specifically set forth in CPT codes 99492, 99493, 99494, 99484, and GCLO1. This BH care delivery approach allows care to be delivered by a PCP or other eligible clinician who is supported by a BH care manager (virtually or in-person) and a consulting psychiatrist (virtually).

Inpatient facility: (a) A hospital, non-hospital-based facility or residential treatment facility, including all medical and surgical admission to general acute care hospitals, long-term acute care hospitals, inpatient rehabilitation facilities, and skilled nursing facilities and (b) all mental health/substance use disorder (MH/SUD) admissions to psychiatric hospitals, general acute care hospitals, non-hospital based inpatient facilities, and residential treatment facilities.

Measurement-Based Care (MBC): The systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient in order to optimize the efficiency, accuracy and consistency of symptom assessment and to maximize the likelihood that nonresponse to treatment is detected by the provider.

Member: Insured subscriber and any dependents insured under the employer group health plan.

MH/SUD: Mental Health/Substance Use Disorder

M/S: Medical/Surgical

N/A: Not applicable

Office visit: A non-facility-based medical/surgical (PCP only) or MH/SUD office visit.

Out-of-Network benefits: Refers to plan coverage for non-emergency MH/SUD services received by members from qualified providers not participating in TPA's provider network.

Outpatient facility: (a) Physical, occupational, speech and cardiovascular therapy, surgeries, radiology, pathology, and pharmacy service for medical or surgical care provided in an outpatient facility setting; and (b) intensive outpatient and partial hospitalization services for MH/SUD conditions in an outpatient facility setting.

Primary care providers (PCPs): General practice, family practice, internal medicine, and pediatric medicine physicians.

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One Specified Plan in One Specified Region

Summary of Model Language Workbook

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Plan _____ in Specified Region _____

1. Increase Access In-network (INN) MH/SUD Providers

Section 1(a): Out-of-Network Use, MH/SUD compared to M/S Providers

Table 1(a)(i) -OON Use - Plan Data for Plan Year		
Based on Claims Allowed for the Client's Members, Specified Plan in Specified Region		**Relevance/Implications of Responses**
How many times more often were MH/SUD services provided OON as compared to Medical/Surgical services?	2020	A figure above 1.0 demonstrates that patients received OON care more often for MH/SUD conditions than for M/S conditions. In most cases, patients use OON providers when they are unable to secure timely care from an in-network provider.
Inpatient Facility Stays	x	
Outpatient Facility Visits	x	
Office Visits (For M/S, primary care office visits only)	x	
Was the percentage of all allowed claims for OON services for MH/SUD Providers minus the percentage of all allowed claims for OON services for M/S Providers greater than 5 percentage points? (Yes/No) **"Yes" indicates that a Plan of Correction is required**.		A differential of 5% or greater suggests that members are experiencing greater difficulty in securing timely appointments with in-network providers for MH/SUD care.
Inpatient Facility Stays		
Outpatient Facility Visits		
Office Visits (For M/S, primary care office visits only)		
Were all required Plans of Correction with respect to this workbook submitted and was receipt acknowledged in each case? (Yes/No)		

Based on Claims Allowed for All Members of the Self-Funded Commercial Plans in the Specified Region		Relevance/Implications of Responses
How many times more often were MH/SUD services provided OON as compared to Medical/Surgical services?	2020	A figure above 1.0 demonstrates that patients received OON care more often for MH/SUD conditions than for M/S conditions. In most cases, patients use OON providers when they are unable to secure timely care from an in-network provider.
Inpatient Facility Stays	x	
Outpatient Facility Visits	x	
Office Visits (For M/S, primary care office visits only)	x	
Was the percentage of all allowed claims for OON services for MH/SUD Providers minus the percentage of all allowed claims for OON services for M/S Providers greater than 5 percentage points? (Yes/No)		A differential of 5% or greater suggests that members are experiencing greater difficulty in securing timely appointments with in-network providers for MH/SUD care.
Inpatient Facility Stays		
Outpatient Facility Visits		
Office Visits (For M/S, primary care office visits only)		

Section 1(b): Network Adequacy and Participation for Psychiatrists

Table 1(b)(i) – In-Network Provider Directory Listings – Psychiatrists		
Based on Claims Allowed for the Client's Members, Specified Plan in Specified Region	2020	**Relevance/Implications of Responses**
The percentage of total psychiatrists (including child psychiatrists) who were listed as participating in your provider network during any time in the Applicable Six Months who submitted zero in-network claims during the Applicable Six Months	%	
The percentage of total psychiatrists (including child psychiatrists) who were listed as participating in your provider network during any time in the Applicable Six Months who submitted zero in-network claims or submitted claims for 1 - 4 unique individuals during the Applicable Six Months	%	

Did the number of psychiatrists (including child psychiatrists) who submitted zero in-network claims during the Applicable Six Months constitute more than 10% of the number of psychiatrists (including child psychiatrists) listed as participating in your provider network during the Applicable Six Months in the Plan Year? (Yes/No)	

If "Yes", was a Plan of Correction submitted and receipt acknowledged? (Yes/No)		Psychiatrists listed as participating in the network who are billing for few or no members may not actually be available for members seeking care. Network adequacy and compliance with network adequacy standards should be gauged by actual provider participation.
Did the number of psychiatrists (including child psychiatrists) who submitted zero claims or claims for 1-4 in-network claims during the Applicable Six Months constitute more than 20% of the number of psychiatrists (including child psychiatrists) listed as participating in your provider network during the Applicable Six Months in the Plan Year? (Yes/No)		
If "Yes", was a Plan of Correction submitted and receipt acknowledged? (Yes/No)		
Based on Claims Allowed for <u>All Members of the Self-Funded Commercial Plans in the Specified Region</u>	2020	
The percentage of total psychiatrists (including child psychiatrists) who were listed as participating in your provider network during any time in the Applicable Six Months who submitted zero in-network claims during the Applicable Six Months	%	
The percentage of total psychiatrists (including child psychiatrists) who were listed as participating in your provider network during any time in the Applicable Six Months who submitted zero in-network claims or submitted claims for 1 - 4 unique individuals during the Applicable Six Months	%	

Section 1(c)(i): In-network Reimbursement Rates, M/S Physicians <u>Compared to</u> Psychiatrists

Table 1(c)(i) – Plan Data for Plan Year Medical/Surgical Physicians <u>compared to</u> Psychiatrists		
Based on Claims Allowed for the <u>Client's Members</u>, Specified Plan in Specified Region		**Relevance/Implications of Responses**
Percentage higher in-network reimbursement for PCPs and other M/S physicians <u>compared to</u> psychiatrists	2020	While reimbursement disparity is important to consider when examining adequacy of network participation by psychiatrists, **<u>the goal is not to simply establish reimbursement</u> <u>equivalency between psychiatrists and other physicians</u>**. It's possible that reimbursement to psychiatrists
CPT Code 99213	%	

CPT Code 99214	%	It's possible that reimbursement to psychiatrists can be lower while network participation

Were all required Plans of Correction with respect to this workbook submitted and was receipt acknowledged in each case? (Yes/No)		remains adequate – **if OON utilization rates (PCPs and other M/S physicians compared to psychiatrists) are similar**. If OON use is higher for psychiatrists (as is frequently the case), increasing reimbursement for psychiatrists **above equivalency** may be a necessary step – this is one reason why a growing number of employers have retained Lyra or other firms. Additional steps may include wider-spread adoption of CoCM (reducing demand for psychiatrist appointments), and more efficient and expedited network admission policies and practices.
Based on Claims Allowed for All Members of the Self-Funded Commercial Plans in the Specified Region		
Percentage higher in-network reimbursement for PCPs and other M/S physicians compared to psychiatrists	2020	
CPT Code 99213	%	
CPT Code 99214	%	

Section 1(c)(ii): In-network Reimbursement Rates Indexed to Medicare Rates, M/S Physicians Compared to Psychologists and Clinical Social Workers

Table 1(c)(ii) – Plan Data for Plan Year M/S Physicians compared to Psychologists and Clinical Social Workers Using Medicare Benchmark Comparison		
Based on Claims Allowed for the Client's Members, Specified Plan in Specified Region		**Relevance/Implications of Responses**
Percentage points higher in-network reimbursement for PCPs and other M/S physicians compared to psychologists (relative to Medicare), regarding CPT codes 90834 and 90837	2020	As is the case with psychiatrists, reimbursement disparity (indexed to Medicare) is important to consider when examining adequacy of **network participation for psychologists and clinical social workers – the goal is not to simply establish reimbursement equivalency**. It's possible that reimbursement to these BH providers can be lower while network participation remains adequate – **if OON utilization rates (primary care and other M/S providers compared to these BH providers) are similar**.
CPT Code 90834	pct points	
CPT Code 90837	pct points	
Were all required Plans of Correction with respect to this workbook submitted and was receipt acknowledged in each case? (Yes/No)		

Based on Claims Allowed for All Members of the Self-Funded Commercial Plans in the Specified Region		
Percentage points higher in-network reimbursement for PCPs and other M/S physicians compared to psychologists (relative to Medicare), regarding CPT codes 90834 and 90837	2020	If OON use is higher for psychologists and clinical social workers (as is frequently the case), increasing reimbursement for these BH providers **above equivalency** may be a necessary step – this is one reason why a growing number of employers have retained Lyra or other firms. Additional steps may include wider-spread adoption of CoCM (reducing demand for individual BH specialist appointments), and more efficient and expedited network admission policies and practices.
CPT Code 90834	pct points	
CPT Code 90837	pct points	

Section 1(d): MH/SUD Professional Provider and Facility Admission to Network

Table 1(d)(i) – Data for Self-funded Commercial Plans Within Specified Region		
Was the average number of days to network admission longer for MH/SUD providers than Medical/Surgical providers (Yes/No)?	2020	**Relevance/Implications of Responses**
Inpatient Facility		Lengthy network application procedures discourage provider participation, creating an impediment to establishing an adequate provider network. The time it takes for a MH/SUD provider or facility to be admitted to a TPA's network after submitting an application should be no longer than the time it takes for a M/S provider or facility to be admitted to a TPA's network.
Outpatient Facility Programs		
Office Based		
If Yes, was a Plan of Correction submitted and receipt acknowledged? (Yes/No)		
Inpatient Facility		
Outpatient Facility Programs		
Office Based		

Section 1(e): Ease and Timeliness of Access to In-Network (INN) Providers: M/S vs MH/SUD

Note: Inputs to Tables in Section 1(e) will come from Member Survey and pertain to the period members were enrolled starting January 1, 2019

Table 1(e)(ii)(b) - Members Who Sought But Did Not Receive Care				
	Mental Health	**Substance Use**	**Medical/Surgical**	**Relevance/Implications of Responses**
Percent of members who sought but did not receive Care	%	%	%	Difficulty and delays in finding a new INN provider and securing an appointment lead to abandonment of efforts to obtain needed care for members unable to find or afford the higher OOP costs for OON care.

Table 1(e)(ii)(d) - Of Members Who Sought Care But Did Not Receive Care: Reason				
Reason	**Mental Health**	**Substance Use**	**Medical/Surgical**	**Relevance/Implications of Responses**
Couldn't find an in-network provider in my area	%	%	%	Understanding the reasons that members ultimately do not receive needed care initially sought from an INN provider informs changes that may be needed to network and benefit design to ensure that members seeking care are able to receive it in a timely, affordable manner.
Could find an in-network provider in my area but they were not taking new patients	%	%	%	
Couldn't afford an in-network provider in my area	%	%	%	
Couldn't find an out-of-network provider in my area	%	%	%	
Could find an out-of-network provider in my area but they were not taking new patients	%	%	%	
Couldn't afford an out-of-network provider in my area	%	%	%	
My insurance plan would not pay for the provider I found and wanted to see	%	%	%	
The wait time to see an in-network provider was too long	%	%	%	
The wait time to see an out-of-network provider was too long	%	%	%	
I was not comfortable with the providers that I found, due to language, cultural or other factors	%	%	%	
My insurance plan did not cover Tele-health visits	%	%	%	
I did not have a device that supported video Tele-health, and my insurance plan did not pay for audio-only Tele-health (i.e., telephone call)	%	%	%	
My insurance plan covered Tele-health but I couldn't find a Tele-health provider who accepted my insurance	%	%	%	
Other	%	%	%	

Table 1(e)(ii)(f) - Members Who Received INN Care: Ease of Access to New INN Provider				Relevance/Implications of Responses
	Mental Health	**Substance Use**	**Medical/Surgical**	
Percent of Members seeing at least one new In-Network provider during the Survey Period	%	%	%	
Table 1(e)(ii)(g) - Number of New In-Network Providers Seen				
Number of new INN providers seen by Members	**Mental Health**	**Substance Use**	**Medical/Surgical**	
1 new INN provider	%	%	%	
2 new INN providers	%	%	%	
3 or more new INN providers	%	%	%	
Table 1(e)(ii)(i) - Number of New In-Network Providers Contacted				
Number of new INN Providers contacted	**Mental Health**	**Substance Use**	**Medical/Surgical**	
1 - 3 providers	%	%	%	Difficulty and delays in finding a new INN provider and securing an appointment lead to: (1) higher OON utilization; (2) higher out-of-pocket (OOP) costs for members receiving OON care; and (3) abandonment of efforts to obtain needed care for members who cannot afford the higher OOP costs for OON .
4 - 7 providers	%	%	%	
7 - 9 providers	%	%	%	
10 or more providers	%	%	%	
Table 1(e)(ii)(j) - Search Times				
Length of time between Member starting search for a new INN provider and scheduling an appointment	**Mental Health**	**Substance Use**	**Medical/Surgical**	
0 - 4 hours	%	%	%	TPAs should ensure that the time it takes members to find a new INN provider ("search times") and obtain an appointment ("wait times") are **not longer** for members seeking MH/SUD care than for members seeking M/S care.
4 - 24 hours	%	%	%	
1 - 6 days	%	%	%	
Between 1 - 2 weeks	%	%	%	
Between 2 weeks - 1 month	%	%	%	
Between 1 - 2 months	%	%	%	
Over 2 months	%	%	%	

Table 1(e)(ii)(k) - Wait Times			
Length of time between scheduling an appointment and Member seeing the new INN provider	**Mental Health**	**Substance Use**	**Medical/Surgical**
0 - 4 hours	%	%	%
4 - 24 hours	%	%	%
1 - 6 days	%	%	%
Between 1 - 2 weeks	%	%	%
Between 2 weeks - 1 month	%	%	%
Between 1 - 2 months	%	%	%
Over 2 months	%	%	%

2. Expand Implementation of the Collaborative Care Model ("CoCM")

Section 2(a): Volume of Allowed CoCM Claims

Table 2(a)(i): CoCM Reporting - INN Providers		
In-network data	2020	**Relevance/Implications of Responses**
The volume of claims paid to PCPs and to other eligible clinicians (combined) with respect to each of the following CoCM codes		CoCM increases access to MH/SUD care by integrating this care into the primary care setting, where most MH/SUD patients receive care. Few or no claims paid for CoCM codes suggests TPA may not be reimbursing for these codes, reimbursing inadequately, or not promoting expansion of CoCM within its provider network.
CPT Code 99492		
CPT Code 99493		
CPT Code 99494		
The percentage of significant healthcare providers (defined as a provider with at least 20 PCPs) that actively billed for any of the following CoCM codes		
CPT Code 99492	%	
CPT Code 99493	%	
CPT Code 99494	%	
The number of unique patients for whom at least one CoCM code was paid		
All Codes Combined		

Table 2(a)(ii): CoCM Reporting - OON Providers		
Out-of-network data	2020	**Relevance/Implications of Responses**
The volume of claims paid to PCPs and to other eligible clinicians (combined) with respect to each of the following CoCM codes		CoCM increases access to MH/SUD care by integrating this care into the primary care setting, where most MH/SUD patients receive care. Few or no claims paid for CoCM codes suggests TPA may not be reimbursing for these codes, reimbursing inadequately, or not promoting expansion of CoCM within its provider network.
CPT Code 99492		
CPT Code 99493		
CPT Code 99494		
The percentage of significant healthcare providers (defined as a provider with at least 20 PCPs) that actively billed for any of the following CoCM codes		
CPT Code 99492	%	
CPT Code 99493	%	
CPT Code 99494	%	
CPT Code 99484	%	
The number of unique patients for whom at least one CoCM code was paid		
All Codes Combined		

Section 2(b)(i): In-network Provider Reimbursement Indexed to Medicare for CoCM Codes

Table 2(b)i Part 3: Adequacy of Premium Paid Relative to Medicare for CoCM Codes		
Was the "premium to Medicare" for the CoCM codes at least as high as the premium for 99213 and 99214 (combined)? (Yes/No)	2020	**Relevance/Implications of Responses**
CPT Code 99492		Client wants to promote rapid expansion of CoCM. TPAs typically pay PCPs for E&M codes (99213 and 99214) at a significant premium above Medicare rates. These is no reason for PCPs to be paid for MH/SUD services at a lower rate (relative to Medicare) when services are delivered pursuant to the CoCM codes.
CPT Code 99493		
CPT Code 99494		
If "No", was a Plan of Correction submitted and receipt acknowledged? (Yes/No)		
CPT Code 99492		
CPT Code 99493		
CPT Code 99494		

Section 2(b)(ii): Benefit Design Barriers: Member Out-of-Pocket Costs and Billing Code Limits

Table 2(b)(ii): Waiver of Patient Out-of-Pocket Costs and Elimination of Billing Limits for CPT 99494		
For CoCM, were patient out-of-pocket costs waived? (Yes/No)	2020	**Relevance/Implications of Responses**
CPT Code 99492		To promote expanded use of CoCM (a low cost behavioral care approach that is proven to significantly improve clinical outcomes and reduce total healthcare costs), barriers uch as member out-of-pocket expenses and billing restrictions on CPT 99494 should be eliminated. Utilization of CoCM for members with mild/moderate conditions promotes early detection and reduces demand for visits to higher cost (and more scarce) in-network MH/SUD providers.
CPT Code 99493		
CPT Code 99494		
If "No", was a Plan of Correction submitted and receipt acknowledged? (Yes/No)		
CPT Code 99492		
CPT Code 99493		
CPT Code 99494		
For CoCM, were limits on the frequency of use of 99494 eliminated? (Yes/No)		
If "No", was a Plan of Correction submitted and receipt acknowledged? (Yes/No)		

Section 2(c)(i): Provider Outreach: CoCM Information

Table 2(c)(i): CoCM Information and Outreach		Relevance/Implications of Responses
	2020	TPA should demonstrate active promotion and support of CoCM among PCPs in TPA's network, to increase member access to MH/SUD care and ensure that MH/SUD care provided by PCPs is evidence based. This should include provision of financial incentives for CoCM implementation, training and support
Number of medical providers informed that TPA is reimbursing for CoCM codes		

Section 2(c)(ii): Provider Training and Technical Support

Table 2(c)(ii): Training and Technical Support

	2020	activities – all of which are critical determinants of successful GeGM implementation

Total $ amount of grants awarded for implementing and expanding use of CoCM	$ -	of successful CoCM implementation.

3. Expand Screening for and Monitoring of MH/SUD with Measurement-Based Care ("MBC")

Section 3(a): HEDIS Reporting

Table 3(a): HEDIS Reporting		
Percent of Commercial ACOs and other VBP-contracted providers in this Specified Region that regularly reported this HEDIS Data Measurement	2020	**Relevance/Implications of Responses**
Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	%	ACOs and other providers under value-based contracts should be reporting HEDIS measurements related to depression care that are already used by Medicare.
Depression Remission at Twelve (12) Months	%	

Section 3(b): Demonstration of Written Support for MBC

Table 3(b): Written support to require MH/SUD MBC for both M/S and MH/SUD providers		
	2021	**Relevance/Implications of Responses**
Number of letters of support written to URAC, The Joint Commission, NCQA and CARF, urging that use of MH/SUD MBC be required for both M/S and MH/SUD providers.		Support from TPAs for major accrediting organizations to require MBC in the treatment of MH/SUD is critical to improving quality of MH/SUD care.

Section 3(c): Promotion of MBC in Treatment of MH/SUD

Table 3(c): Promote MH/SUD MBC		
Percentage of providers who consistently used standardized MH/SUD symptom measurement tools	2020	**Relevance/Implications of Responses**

MH/SUD Providers	%	TPAs should actively promote MBC for diagnosing and treating MH/SUDs. Use of

M/S Providers	%	validated diagnostic and treatment tools ensures TPA and provider accountability.

4. Sustain Expanded Access to Tele-Behavioral Health ("TBH") Services

Section 4(a): TBH Coverage and Reimbursement

Table 4(a)(i): TBH Coverage		
Were MH/SUD providers reimbursed for the following TBH treatment modalities? (Yes/No)	2020	**Relevance/Implications of Responses**
In-Network		Evidence supports the effectiveness of both audio-only (telephonic) and video TBH, and not all members have access to devices and facility in using video TBH.
Audio-only		
Video		
Out-of-Network		
Audio-only		
Video		
Were all required Plans of Correction submitted and receipt acknowledged in each case? (Yes/No)		

Table 4(a)(ii): TBH Reimbursement		
Were the allowed amounts for the following TBH treatment modalities the same as the allowed amounts for in-person office visits? (Yes/No)	2020	**Relevance/Implications of Responses**
In-Network		Evidence supports the effectiveness of both audio-only and video TBH. TPA should reimburse the same amount to providers for both of these modalities as well as face-to-face treatment, to facilitate access to needed MH/SUD care and permit true member choice of modality in doing so.
Audio-only		
Video		
Out-of-Network		
Audio-only		
Video		
Were all required Plans of Correction submitted and receipt acknowledged in each case? (Yes/No)		

Section 4(b): Tele-Behavioral Health Data Reporting

Table 4(b)(i): TBH Spending and Allowed Claims Data		Relevance/Implications of Responses
Percentage of non-facility based claims allowed	2020	Employers should understand the TBH modalities covered by their TPA(s), whether reimbursement across modalities supports member choice of modalities, and how quality is monitored and maintained within TPA's network. Data regarding allowed TBH claims by modality, allowed amounts for high-volume TBH codes and use of MBC among TPA's third party TBH providers help to ensure accountability in maintaining expanded access to MH/SUD care for members through TBH.
In-Network		
TBH Audio-only	%	
TBH Video	%	
In-person	%	
Out-of-Network		
TBH Audio-only	%	
TBH Video	%	
In-person	%	

Table 4(b)(ii): In-network Reimbursement Information for non-facility based treatment services: Allowed amounts reimbursed for the 10 highest volume TBH codes	
	2020
Percentage of the 10 highest volume TBH codes for which Audio-only, Video, and In-person used the same allowed amount	%

Table 4(b)(iii): Listing of which of the TPA's "third party TBH providers" were using MBC	
	2020
Names of third party TBH providers that were using MBC	

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One Specified Plan in One Specified Region

Increase In-network Access to MH/SUD Providers
Appendix for Model Language Section 1(a)
Out-of-network Use, MH/SUD Compared to M/S Providers

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Plan _____ in Specified Region _____

Complete this Section 1(a) only for each Specified Plan that has Out-of-Network ("OON") benefits. Utilize total claims allowed for both In-Network and Out-of-Network services. Complete Table 1(a)(i) with respect to the percentage of all allowed claims that were for Out-of-Network (OON) services. *Note: Claims "allowed" are sometimes referred to as claims "paid", and consist of claims approved for payment by the TPA. In some cases, the actual payment may be the member's responsibility, either in whole or in part (e.g., unmet deductible, copay or coinsurance). However, all claims approved for payment by the TPA are considered "allowed" claims.*

Please refer to the Instructions tab for definitions of Inpatient Facility, Outpatient Facility, and Office visit.

Table 1(a)(i) -OON Use - Plan Data for Plan Year

	Based Only on Claims for Client's Members				Based on Claims for All Members of Self-Funded Plans in the Specified Region	
	Column A	Column B	Column C	Column D	Column CC	Column DD
Setting	Medical/Surgical Providers: Percentage of all allowed claims that were for OON services	MH/SUD Providers: Percentage of all allowed claims that were for OON services	Percentage of all allowed claims for OON services for MH/SUD Providers minus percentage of all allowed claims for OON services for Medical/Surgical Providers	How many times more often were MH/SUD services provided OON as compared to Medical/Surgical services?	Percentage of all allowed claims for OON services for MH/SUD Providers minus percentage of all allowed claims for OON services for Medical/Surgical Providers	How many times more often were MH/SUD services provided OON as compared to Medical/Surgical services?
Inpatient Facility Stays	%	%	pct points	x	pct points	x
Outpatient Facility Visits	%	%	pct points	x	pct points	x

Office Visits (For M/S, use primary care office visits only)	%	%	pct points	x	pct points	x

In Column C, if the percentage of all allowed claims for OON services for MH/SUD Providers minus the percentage of all allowed claims for OON services for Medical/Surgical Providers is more than 5 percentage points for inpatient facility, outpatient facility or office visits, provide a **Plan of Correction** as indicated in Table 1(a)(ii).

The **Plan of Correction** should include: Specific steps you will undertake to reduce OON use of MH/SUD providers, for example: increasing in-network reimbursement rates, by how much and during what time period; reducing utilization review "hassle factors" such as frequency of reviews, time constraints within which peer to peer reviews must be conducted, paperwork (e.g., written treatment plans and updates) not required for M/S providers; overall micromanagement of cases resulting in increased provider administrative costs; length of time it takes for a provider to be credentialed join the network; other delays in network provider admission; restraints on appeals for denied care; etc.

Table 1(a)(ii) Plan of Correction

Setting	Column A **In Column C in table 1(a)(i), was the Percentage of all allowed claims for OON services for MH/SUD Providers minus the percentage of all allowed claims for OON services for Medical/Surgical Providers greater than 5 percentage points? (Yes/No)**	Column B **If "Yes", was a Plan of Correction submitted and receipt acknowledged? (Yes/No)**	Column C **If "Yes", to whom was the Plan of Correction submitted?**
Inpatient Facility Stays			
Outpatient Facility Visits			
Office Visits (For M/S, primary care office visits only)			

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One Specified Plan in One Specified Region

Increase In-network Access to MH/SUD Providers
Appendix for Model Language Section 1(b)
Network Adequacy and Participation for Psychiatrists

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Plan _____ in Specified Region _____

Using Table 1(b)(i), provide information regarding your MH/SUD provider network in the Specified Region.

Data should include inpatient facility, outpatient facility and office visit settings (combined) and be completed for the "Applicable Six Months" as defined in Row 1 of Table 1(b)(i).

	Table 1(b)(i) – In-Network Provider Directory Listings – Psychiatrists	**Response**	
		Col. A	**Col. B**
		Specified Plan in Specified Region	**All TPA Members in Self-funded Commercial Plans in Specified Region**
1	Total number of psychiatrists (including child psychiatrists) who were listed as participating in your MH/SUD provider network in the Specified Region during any time in the last 6 months of the Plan Year ("**Applicable Six Months**"):		
2	Total number of unique members of the Specified Plan in the Specified Region:		
3	Number of psychiatrists (including child psychiatrists) who submitted zero in-network claims relating to the members of the Specified Plan in the Specified Region during the Applicable Six Months:		
4	Number of psychiatrists (including child psychiatrists) who submitted in-network claims for 1 to 4 unique members of the Specified Plan in the Specified Region during the Applicable Six Months:		
5	Number of psychiatrists (including child psychiatrists) who submitted in-network claims for 5 or more unique members of the Specified Plan in the Specified Region during the Applicable Six Months:		
6	Does the sum of the numbers in Rows 3, 4 and 5 equal the number in Row 1? (Yes/No) **If "No", amend responses as needed so that there is equality**.		
7	The percentage of total psychiatrists (including child psychiatrists) who were listed as participating in your provider network during any time in the Applicable Six Months who submitted zero in-network claims during the Applicable Six Months:	%	%
8	Add Rows 3 and 4, which is the number of psychiatrists (including child psychiatrists) who submitted zero in-network claims or submitted claims for 1 - 4 unique individuals during the Applicable Six Months:		

9	The percentage of total psychiatrists (including child psychiatrists) who were listed as participating in your provider network during any time in the Applicable Six Months who submitted zero in-network claims or submitted claims for 1 - 4 unique individuals during the Applicable Six Months:	%	%

If, in Column A, the percentage listed in Row 7 is above 10% or the percentage listed in Row 9 is above 20%, provide a **Plan of Correction**.

Your **Plan of Correction** should describe how you will address network provider adequacy, including monitoring actual provider network participation, and improving and ensuring compliance with network adequacy standards (including wait times) to ensure sufficient and timely access to network providers, etc.

Table 1(b)(ii) Plan of Correction		
	Zero Claims	**Zero Claims or claims for 1 - 4 unique individuals**
Did the number of psychiatrists (including child psychiatrists) who submitted zero in-network claims during the Applicable Six Months constitute more than 10% of the number of psychiatrists (including child psychiatrists) listed as participating in your provider network during the Applicable Six Months in the Plan Year? (Yes/No)		
If "Yes", was a Plan of Correction submitted and receipt acknowledged? (Yes/No)		
If "Yes", to whom was the Plan of Correction submitted?		
Did the number of psychiatrists (including child psychiatrists) who submitted zero claims or claims for 1-4 in-network claims during the Applicable Six Months constitute more than 20% of the number of psychiatrists (including child psychiatrists) listed as participating in your provider network during the Applicable Six Months in the Plan Year? (Yes/No)		
If "Yes", was a Plan of Correction submitted and receipt acknowledged? (Yes/No)		
If "Yes", to whom was the Plan of Correction submitted?		

Table 1(b)(iii) Specified Region Overall Network Information		**Response**
1	Total number of psychiatrists (including child psychiatrists) who were listed as participating in your MH/SUD provider network in the Specified Region during any time in the last 6 months of the Plan Year ("**Applicable Six Months**"):	
2	Number of in-network psychiatrists who were child psychiatrists:	
3	Total number of unique covered lives in the Specified Region (not just members of the Specified Plan) that used the same MH/SUD network as the members of the Specified Plan.	
4	Ratio of in-network psychiatrists (including child psychiatrists) to total unique covered lives in the Specified Region, indicated as 1:xxx (xxx = Row 3/Row 1)	

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One Specified Plan in One Specified Region

Increase In-network Access to MH/SUD Providers
Appendix for Model Language Section 1(c)(i)

In-network Reimbursement Rates
M/S Physicians Compared to Psychiatrists

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Plan _____ in Specified Region _____

For In-Network provider office visits only, for the CPT codes provided in Table 1(c)(i) (below), provide the weighted average allowed amounts for the following groups of providers:

• *Primary Care Physicians, "PCPs"* , defined as general practice, family practice, internal medicine, and pediatric medicine physicians.
• *Non-psychiatrist Medical/Surgical Specialist Physicians* , defined to include non-psychiatrist specialty physicians, such as orthopedic surgeons, dermatologists, neurologists, etc. This category excludes PCPs.
• *Psychiatrists* , including child psychiatrists.

Instructions for completing Table 1(c)(i):
• In Rows 1– 4, insert the weighted average in-network allowed amounts (weighted by the proportion of claims allowed at each allowed amount level) for Column A (CPT 99213) and Column B (99214). This calculation will provide the same result as calculating the sum of the allowed amounts for every in-network 99213 and 99214 claim that was allowed for PCPs, and dividing that sum by the total number of such claims allowed for PCPs.
• In Row 5, insert the percentage amount (if any) by which the in-network reimbursement for PCPs and other non-psychiatrist M/S specialist physicians (combined) was greater than for psychiatrists (Example 1: 110/98 = 1.12 - 1 = 0.12 x 100 = 12%. Example 2: 105/108 = 0.97 - 1 = -0.03 x 100 = -3%).

Table 1(c)(i) - Plan Data for Plan Year Medical/Surgical Physicians compared to Psychiatrists			
	Description	**Column A**	**Column B**
	In-Network Office Visits Only (non-facility based)	**CPT Code 99213**	**CPT Code 99214**
1*	Weighted average allowed amount for primary care physicians (PCPs)	$	$
2*	Weighted average allowed amount for non-PCP, non-psychiatrist M/S specialist physicians	$	$
3*	Weighted average allowed amount for PCPs and non-psychiatrist M/S specialist physicians (combined)	$	$

4*	Weighted average allowed amount for psychiatrists, including child psychiatrists	$	$
5*	Percentage higher in-network reimbursement for PCPs and other M/S physicians compared to psychiatrists (i.e., ((Row 3/Row 4) - 1) x 100. If this calculation results in zero or a negative number, there was no "higher in-network reimbursement".)	%	%
6**	Percentage higher in-network reimbursement for PCPs and other M/S physicians compared to psychiatrists. If this calculation results in zero or a negative number, there was no "higher in-network reimbursement".)	%	%

* Based on only claims allowed for the client's members
** Based on claims allowed for all members of TPA in self-funded commercial plans in the Specified Region

Table 1(c)(i) Comparisons to be conducted:

If, with respect to claims allowed for the client's members, PCPs and non-psychiatrist M/S specialist physicians (combined) received higher in-network reimbursement than psychiatrists (i.e., the amount in Row 5, Column A and/or Row 5, Column B is a positive percentage amount), provide a **Plan of Correction**.

Your **Plan of Correction** should include an explanation of your plan to increase in-network reimbursement rates for psychiatrists (including by how much and during what time period), as an economic incentive for more psychiatrists to join the network. If OON use is higher for psychiatrists (frequently the case), increasing reimbursement for psychiatrists above equivalency may be a necessary step.

Table 1(c)(i) Comparisons & Plan of Correction		
In-Network Office Visits Only (non-facility based)	**CPT Code 99213**	**CPT Code 99214**
Did PCPs and non-psychiatrist M/S specialist physicians (combined) receive higher in-network reimbursement than psychiatrists (i.e., is the amount in Table 1(b)(i), Row 5, Column A and/or Row 5, Column B a positive percentage amount)? (Yes/No)		
If "Yes", was a Plan of Correction submitted and receipt acknowledged? (Yes/No)		
If "Yes", to whom was the Plan of Correction submitted?		

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One Specified Plan in One Specified Region

Increase In-network Access to MH/SUD Providers
Appendix for Model Language Section 1(c)(ii)
In-network Reimbursement Rates Indexed to Medicare Rates
M/S Physicians Compared to Psychologists and Clinical Social Workers

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Plan _____ in Specified Region _____

For In-Network provider office visits only, for the CPT codes provided in the tables below, provide the weighted average allowed amounts for the following groups of providers:

• *Primary Care Physicians* , "PCPs", defined as general practice, family practice, internal medicine, and pediatric medicine physicians.
• *Non-psychiatrist Medical/Surgical Specialist Physicians* , defined to include non-psychiatrist specialty physicians, such as orthopedic surgeons, dermatologists, neurologists, etc. This category excludes PCPs.
• *Psychiatrists* , including child psychiatrists.
• *Non-psychiatrist Behavioral Health ("BH") Professionals* , defined as psychologists and clinical social workers.

Weighted average allowed amounts is defined as weighting allowed amounts by the proportion of claims allowed at each allowed amount level. This will provide the same result as calculating the sum of the allowed amounts for every claim that was allowed for these providers, and dividing that sum by the total number of claims allowed for such providers.

There is only one National Medicare Physician Fee Schedule allowed amount for all providers participating in Medicare for the following four (4) CPT codes for which data is requested: 99213, 99214, 90834 and 90837. The Medicare fee schedule allowed amounts for non-facility based services for 2020 are inserted into the tables and can be verified by following the instructions in footnote below (**). Provider locality adjustments have not been taken into account for regional markets, as the testing herein is comparative (i.e., indexed to Medicare rates), rather than absolute, and will thus yield useful allowed amount comparative information irrespective of region.

Table 1(c)(ii)(a) - For Client's Members Only
Plan Data for Plan Year
Medical/Surgical Physicians compared to Psychologists and Clinical Social Workers
for CPT Codes 99213 & 90834, Indexed to National Medicare Fee Schedule

			Column A	Column B	Column C
	Provider Type	**CPT Codes**	**Plan Weighted Average Allowed Amount**	**National Medicare Fee Schedule Amount**	**Plan Weighted Average Allowed Amount as a Percentage of Medicare**
1	PCPs and MD Specialist Physicians* (combined)	99213	$	$76.15	%
2	Psychologists	90834	$	$94.56	%
3	Clinical Social Workers	90834	$	$70.92	%

Table 1(c)(ii)(b) - For Client's Members Only
Plan Data for Plan Year
Medical/Surgical Physicians compared to Psychologists and Clinical Social Workers
for CPT Codes 99214 & 90837, Indexed to National Medicare Fee Schedule

			Column A	Column B	Column C
	Provider Type	**CPT Codes**	**Plan Weighted Average Allowed Amount**	**National Medicare Fee Schedule Amount**	**Plan Weighted Average Allowed Amount as a Percentage of Medicare**
1	PCPs and MD Specialist Physicians* (combined)	99214	$	$110.43	%
2	Psychologists	90837	$	$141.47	%
3	Clinical Social Workers	90837	$	$106.10	%

Table 1(c)(ii)(c) - For All Covered Lives of TPA in Self-Funded Commercial Plans in the Specified Region
Plan Data for Plan Year
Medical/Surgical Physicians compared to Psychologists and Clinical Social Workers for CPT Codes 99213 & 90834, Indexed to National Medicare Fee Schedule

			Column A	Column B	Column C
	Provider Type	**CPT Codes**	**Plan Weighted Average Allowed Amount**	**National Medicare Fee Schedule Amount**	**Plan Weighted Average Allowed Amount as a Percentage of Medicare**
1	PCPs and MD Specialist Physicians* (combined)	99213	$	$76.15	%
2	Psychologists	90834	$	$94.56	%
3	Clinical Social Workers	90834	$	$70.92	%

Table 1(c)(ii)(d) - For All Covered Lives of TPA in Self-Funded Commercial Plans in the Specified Region
Plan Data for Plan Year
Medical/Surgical Physicians compared to Psychologists and Clinical Social Workers for CPT Codes 99214 & 90837, Indexed to National Medicare Fee Schedule

			Column A	Column B	Column C
	Provider Type	**CPT Codes**	**Plan Weighted Average Allowed Amount**	**National Medicare Fee Schedule Amount**	**Plan Weighted Average Allowed Amount as a Percentage of Medicare**
1	PCPs and MD Specialist Physicians* (combined)	99214	$	$110.43	%
2	Psychologists	90837	$	$141.47	%
3	Clinical Social Workers	90837	$	$106.10	%

* MD specialist physicians does not include psychiatrists for purposes of this data.

Tables 1(c)(ii)(a) and 1(c)(ii)(b) Comparisons to be conducted:

If, with respect to claims allowed for the client's members, the percentage in **Column C, Row 1** is higher than the percentage in **Column C, Row 2 or 3** in either one and/or both of the Tables 1(c)(ii)(a) and 1(c)(ii)(b) above, indicating that PCPs and MD specialist physicians (combined) receive higher allowed amounts relative to the National Medicare Fee Schedule than psychologists and/or clinical social workers, provide a **Plan of Correction**.

Your **Plan of Correction** should include an explanation of your plan to increase in-network reimbursement rates for psychologists and/or social workers (including by how much and during what time period), as an economic incentive for more psychologists and/or social workers to join the network. If OON use is higher for psychologists and/or social workers (frequently the case), increasing reimbursement for psychologists and/or social workers above equivalency may be a necessary step.

Table 1(c)(ii) Comparisons & Plan of Correction				
Description	**Psychologists**		**Social Workers**	
	CPT 90834	**CPT 90837**	**CPT 90834**	**CPT 90837**
Did PCPs and non-psychiatrist M/S specialist physicians (combined) receive higher in-network reimbursements (Row 1, Column C) relative to Medicare than psychologists and/or clinical social workers (Rows 2 and 3, Column C)? (Yes/No)				
If "Yes", was a Plan of Correction submitted and receipt acknowledged? (Yes/No)				
If "Yes", to whom was the Plan of Correction submitted?				

** The Medicare Physician Fee Schedule can be found at: https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

1. Accept license for use
2. Select the last complete calendar year
3. Select “Pricing Information”
4. Select “List of HCPCS Codes”
5. Select “National Payment Amount”
6. Enter codes 99213, 99214, 90834, and 90837
7. Select “All Modifiers”
8. Click "Submit"
9. Please utilize the “Non-Facility Price” column.

For further help, refer to the one page “Medicare Physician Fee Schedule (MPFS) Quick Reference Search Guide” for a step-by-step summary of how to use the MPFS: https://www.cms.gov/apps/physician-fee-schedule/help/How_to_MPFS_Booklet_ICN901344.pdf (pg 29)

The 75% adjustment for Clinical Social Workers Services can be found in the “Medicare Claims Processing Manual,” Chapter 12, “Physicians/Nonphysician Practitioners” at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf.

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One Specified Plan in One Specified Region

Increase In-network Access to MH/SUD Providers
Appendix for Model Language Section 1(d)
MH/SUD Professional Provider and Facility Admission to Network

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Plan _____ in Specified Region _____

Using Table 1(d)(i), provide data regarding the average time elapsed to admit MH/SUD providers (inpatient facility, outpatient facility programs and office based) into the network.

Table 1(d)(i) - Data for Self-funded Commercial Plans Within Specified Region			
	Column A	**Column B**	**Column C**
	Medical/Surgical Providers	**MH/SUD Providers**	**Difference in days between MH/SUD providers vs. Medical/Surgical providers (Column B minus Column A)**
Provider Type	**Average number of days between submission of application and effective date of provider contract**	**Average number of days between submission of application and effective date of provider contract**	
Inpatient Facility			
Outpatient Facility Programs			
Office Based			

If the difference in Column C is a positive number (i.e., the length of time to network admission for MH/SUD providers is longer than for Medical/Surgical providers), provide a **Plan of Correction**.

The **Plan of Correction** should include: Specific steps you will undertake to reduce length of time it takes for MH/SUD providers to be admitted to TPA's network.

Table 1(d)(ii) Plan of Correction			
	Column A	**Column B**	**Column C**
Provider Type	**In Column C in Table 1(d)(i), was the average number of days to network admission longer for MH/SUD providers than Medical/Surgical providers? (Yes/No)**	**If "Yes", was a Plan of Correction submitted and receipt acknowledged? (Yes/No)**	**If "Yes", to whom was the Plan of Correction submitted?**
Inpatient Facility			
Outpatient Facility			
Office Based			

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One Specified Plan in One Specified Region

Increase In-network Access to MH/SUD Providers
Appendix for Model Language Section 1(e)
Ease and Timeliness of Access to In-Network (INN) Providers: M/S vs

1(e)(i) Quantitative "Search Time" and "Wait Time" Standards for INN Care

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Plan _____ in Specified Region _____

This section **relates to TPA's** existing written standards regarding "Search Times" (the length of time required for a patient to find a new **In-Network (INN)** provider and schedule an appointment) and "Wait Times" (the length of time from the date when **an appointment** time is arranged to the date of the appointment.

If there is no written standard, insert "None" in the appropriate cell.

Table 1(e)(i)(a) - Urgent Care Search and Wait Time Standards (Maximum Acceptable Time)						
	Medical/Surgical		Mental Health		Substance Use	
Hours	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient
Search Time						
Wait time						

Table 1(e)(i)(b) - Routine Care Search and Wait Time Standards (Maximum Acceptable Time)						
	Medical/Surgical		Mental Health		Substance Use	
Days	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient
Search Time						
Wait time						

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One Specified Plan in One Specified Region

Increase In-network Access to MH/SUD Providers
Appendix for Model Language Section 1(e)
Ease and Timeliness of Access to In-Network (INN) Providers: M/S vs MH/SUD

1(e)(ii) Survey of Member "Search Times", "Wait Times" and Receipt of Care related to Care Sought From New INN Providers

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Plan _____ in Specified Region _____

This section outlines requirements for TPA to retain a 3rd party independent firm to survey a statistically valid sample of randomly-selected Members of the Specified Plan to determine: (1) whether Care sought from a new INN provider (an INN provider whom the Member has not seen before) was received; (2) if not, why not; (3) how long it took the Member to find an INN provider; and, if an appointment was scheduled with the INN provider, what was the "wait time" until the Member actually saw the new INN provider.

Sample survey questions are located in tab 1(e)(iii).

Tables 1(e)(ii)(a) through 1(e)(ii)(k) below should be completed based on results obtained from the survey.

Please refer to definitions listed in tab 1(e)(iii) for completion of these tables.

Part 1: Members Who Sought Care

Table 1(e)(ii)(a) - Percent of Members who sought Care during the Survey Period			
	Percent of Members		
	Mental Health	**Substance Use**	**Medical/ Surgical**
Percent of Members who sought Care from one or more providers during the Survey Period	%	%	%

Part 2: Members Who Sought but Did Not Receive Care

Table 1(e)(ii)(b) - Percent of Members who sought but did not receive Care during the Survey Period			
	Percent of Members		
Percent of Members who sought but did not receive Care	**Mental Health**	**Substance Use**	**Medical/ Surgical**
Total (sought Care one or more times)	%	%	%
Sought Care one time	%	%	%
Sought Care two or more times	%	%	%

Table 1(e)(ii)(c) - Urgency of Care Sought but Not Received, by Percentage			
***Note** : In the tables below, if Care was sought more than one time during the Survey Period, Member is asked to respond with regard to the single most important time Care was sought.*			
The single most important time can involve more than 1 of the 6 categories of Care below.			
	Percentage Distribution: Level of Care Sought but Not Received		
Focusing on the single most important time when Care was sought but not received, what level of Care was sought?	**Mental Health**	**Substance Use**	**Medical/ Surgical**
Outpatient Services (Including Tele-health) Total	%	%	%
(1) Urgent	%	%	%
(2) Routine	%	%	%
Inpatient Services Total	%	%	%
(1) Urgent	%	%	%
(2) Routine	%	%	%
Prescription Drugs Total	%	%	%
(1) Urgent	%	%	%
(2) Routine	%	%	%

Table 1(e)(ii)(d) - Reasons Why Care Sought Was Not Received			
	Percentage Distribution: Reasons Care Was Not Received		
Reason	**Mental Health**	**Substance Use**	**Medical/ Surgical**
Couldn't find an in-network provider in my area	%	%	%
Could find an in-network provider in my area but they were not taking new patients	%	%	%
Couldn't afford an in-network provider in my area	%	%	%
Couldn't find an out-of-network provider in my area	%	%	%
Could find an out-of-network provider in my area but they were not taking new patients	%	%	%
Couldn't afford an out-of-network provider in my area	%	%	%

My insurance plan would not pay for the provider I found and wanted to see	%	%	%

The wait time to see an in-network provider was too long	%	%	%
The wait time to see an out-of-network provider was too long	%	%	%
I was not comfortable with the providers that I found, due to language, cultural or other factors	%	%	%
My insurance plan did not cover Tele-health visits	%	%	%
I did not have a device that supported video Tele-health, and my insurance plan did not pay for audio-only Tele-health (i.e., telephone call)	%	%	%
My insurance plan covered Tele-health but I couldn't find a Tele-health provider who accepted my insurance	%	%	%
Other	%	%	%

Table 1(e)(ii)(e) - Impact of Not Receiving the Care Sought			
	Percentage Distribution: Impact of Not Receiving Care Sought		
Impact of not receiving Care sought	**Mental Health**	**Substance Use**	**Medical/ Surgical**
Condition became worse	%	%	%
Hospital admission	%	%	%
Emergency room visit	%	%	%
Job/employment impacted because of inability to work regular hours or work at all	%	%	%
Lost job/employment	%	%	%
Family life impacted due to inability to maintain job/same level of income	%	%	%
Family life impacted due to increased stress among family members or other reasons	%	%	%
No impact	%	%	%
Other	%	%	%

Part 3: Members Who Sought and Received Care

Table 1(e)(ii)(f) - Members Who Saw at Least One New In-Network Provider			
	Percent of Members		
	Mental Health	**Substance Use**	**Medical/ Surgical**
Percent of Members seeing at least one new In-Network provider during the Survey Period	%	%	%

Table 1(e)(ii)(g) - Number of New In-Network Providers Seen			
	Percentage Distribution: Number of New INN providers seen by Members		
Number of New In-Network Providers Seen	**Mental Health**	**Substance Use**	**Medical/ Surgical**
1 new INN provider	%	%	%
2 new INN providers	%	%	%
3 or more new INN providers	%	%	%

Table 1(e)(ii)(h) - Urgency of Care Received, by Percentage

***Note** : In the tables below, if Care was received by more than one new INN provider during the Survey Period, Member is asked to respond with regard to the single most important new INN provider.*

	Percentage Distribution: Level of Care Received		
Focusing on the single most important new INN provider seen, what level of Care was received?	**Mental Health**	**Substance Use**	**Medical/ Surgical**
Outpatient Services (Including Tele-health) Total	%	%	%
(1) Urgent	%	%	%
(2) Routine	%	%	%
Inpatient Services Total	%	%	%
(1) Urgent	%	%	%
(2) Routine	%	%	%

Table 1(e)(ii)(i) - Number of New In-Network Providers Contacted			
	Percentage Distribution: Number of New INN Providers Contacted		
Number of New INN Providers Contacted	**Mental Health**	**Substance Use**	**Medical/ Surgical**
1 - 3 providers	%	%	%
4 - 7 providers	%	%	%
7 - 9 providers	%	%	%
10 or more providers	%	%	%

Table 1(e)(ii)(j) - Search Time			
	Percentage Distribution: Time to Locate and Schedule Appointment with New INN Provider		
Length of time between Member starting search for a new INN provider and scheduling an appointment	**Mental Health**	**Substance Use**	**Medical/ Surgical**
0 - 4 hours	%	%	%
4 - 24 hours	%	%	%
1 - 6 days	%	%	%
Between 1 - 2 weeks	%	%	%
Between 2 weeks - 1 month	%	%	%
Between 1 - 2 months	%	%	%
Over 2 months	%	%	%

Table 1(e)(ii)(k) - Wait Time			
	Percentage Distribution: Time Between Scheduling Appointment and Member Seeing New INN Provider		
Length of time between scheduling an appointment and Member seeing the new INN provider	**Mental Health**	**Substance Use**	**Medical/ Surgical**
0 - 4 hours	%	%	%
4 - 24 hours	%	%	%
1 - 6 days	%	%	%
Between 1 - 2 weeks	%	%	%
Between 2 weeks - 1 month	%	%	%
Between 1 - 2 months	%	%	%
Over 2 months	%	%	%

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One Specified Plan in One Specified Region

Increase In-network Access to MH/SUD Providers
Appendix for Model Language Section 1(e)
Ease and Timeliness of Access to In-Network (INN) Providers: M/S vs MH/SUD

1(e)(iii) Sample Survey Questions

Survey: Accessibility of Healthcare Providers

[TPA] and [Client] want to assure that you and any family members covered under [Client's Specified Plan] have timely access to healthcare providers in [Client's Specified Plan] provider network for different types of Care. We are reaching out to randomly-selected members under [Client's Specified Plan].

Since we are asking only a portion of [Client's Specified Plan] members to complete this brief survey, **your participation is very important** in helping [TPA] and [Client] make sure that [Client's Specified Plan] members are able to easily find and schedule appointments with **new** In-Network providers when care is needed for a variety of health conditions including medical/surgical, mental health, and substance use treatment.

[TPA] has commissioned [Survey Company] to conduct this survey. [Survey Company] is a leading, independent survey firm. Answers you provide to this survey will never be provided to [TPA], [Client] or anyone else. [Survey Company] will provide to [TPA] and [Client] **only aggregated data provided by the entire group of respondents**.

All of your answers to the questions should pertain to the period beginning January 1, 2019, but including only the time that you and any other members of your family were enrolled in [Specified Plan].

Your participation is greatly appreciated. It should take only about ____ minutes to complete the survey, and your responses will help [Client] ensure that easy access to timely care is being made available to all members covered under your health plan.

Definitions of Terms

Below are definitions for terms that are used in the survey. At any point in the survey, you can click the "**Glossary**" button to review these definitions:

Care: Health services or prescription drugs. Health services could be Inpatient or Outpatient (including Tele-health). Health services can also involve Routine Care or Urgent Care.

In-Network Provider: Providers or health care facilities that are part of a health plan's network of providers. Deductibles, copays, and coinsurance are typically lower when you see an In-Network Provider.

Inpatient Care: Care provided in a setting where you spend the night. Examples include a general hospital, psychiatric hospital, residential treatment facility, rehabilitation facility, or a skilled nursing facility.

Member: An individual enrolled in [Specified Plan], or a family member covered under the [Specified Plan] because of your enrollment in the plan.

Medical/Surgical: Used to describe treatment received for medical conditions/illnesses (versus mental health or substance use treatment).

Mental Health: Emotional and psychological well-being that allows people to use their cognitive (thinking) and emotional capabilities, function in society, and meet the ordinary demands of everyday life. Mental Health and Substance Use care (including prescription drugs) may be provided by a Mental Health Specialist such as a psychiatrist, psychologist or a social worker, or by a primary care doctor or other general medical provider such as an OBGYN.

Out-of-Network Provider: Providers or health care facilities that do not participate in an insurer's provider network. Deductibles, copays, and coinsurance are typically high when you see an Out-of-Network Provider, or you have to pay the entire fee of the provider.

Outpatient Care: Care provided in a setting where you do not spend the night. Examples include a provider's office (doctor, psychiatrist, psychologist, or therapist), urgent care center, other outpatient settings such as intensive outpatient treatment at a facility but on an outpatient basis, and tele-health.

Routine Care: The regular care (non-emergency, non-urgent) you get from your primary care doctor or from other doctors that your PCP sends you to. It includes visits for scheduled check-ups, physical exams, health screenings and ongoing care for chronic health problems like diabetes, high blood pressure and asthma.

Substance Use: Recurrent use of alcohol and/or drugs that causes significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. Mental Health and Substance Use care (including prescription drugs) may be provided by a Mental Health Specialist such as a psychiatrist, psychologist or a social worker, or by a primary care doctor or other general medical provider such as an OBGYN.

Survey Period: The period starting January 1, 2019, but including only those months when you were enrolled in [Specified Plan].

Tele-health: Receiving care from a provider via an "audio-video" connection (for example, Zoom or Facetime) or via an "audio-only" connection (a telephone call).

Urgent Care: Outpatient care for injuries or health conditions requiring immediate attention but not serious enough to require going to an emergency room.

Return to Survey button

Survey Questions:

The following questions relate to types of Care that you or your family members who were covered under your health plan sought during the Survey Period, and your experience obtaining the Care.

Q1. During the Survey Period, did you or a covered family member seek Care (services and/or prescription drugs) for any of the following conditions? Select one answer in each row:

	Was Care Sought			
Health Condition Care was Sought For	01 No	02 Yes, and in all cases, care was received	03 Yes, but in one case, care was not received	04 Yes, but in two or more cases, care was not received
a. Mental health conditions				
b. Substance use conditions				
c. Medical/Surgical conditions				

[Software Programmer: Ask Q2A1, Q2A2, and Q2A3 if respondent didn't receive Care for Mental Health Conditions (Q1 a. = 03 or 04)]

Mental Health Conditions

Q2A1. Focusing on the single most important time when Care was sought but not received by you or a covered family member, what level of Care was sought? Please select all that apply:

	Mental Health					
	Outpatient Services		Inpatient Services		Prescription Drugs	
	Urgent Care	Routine Care	Urgent Care	Routine Care	Urgent Care	Routine Care
Mental Health Conditions						

Q2A2. Focusing on the single most important time when Care was sought but not received by you or a covered family member, why was Care not received? Please select all that apply:

	Mental health
01 Couldn't find an in-network provider in my area	
02 Could find an in-network provider in my area but they were not taking new patients	
03 Couldn't afford an in-network provider in my area	
04 Couldn't find an out-of-network provider in my area	
05 Could find an out-of-network provider in my area but they were not taking new patients	
06 Couldn't afford an out-of-network provider in my area	
07 My insurance plan would not pay for the provider I found and wanted to see	
08 The wait time to see an in-network provider was too long	
09 The wait time to see an out-of-network provider was too long	
10 I was not comfortable with the providers that I found, due to language, cultural or other factors	
11 My insurance plan did not cover Tele-health visits	
12 I did not have a device that supported video Tele-health, and my insurance plan did not pay for audio-only Tele-health (i.e., telephone call)	

13 My insurance plan covered Tele-health but I couldn't find a Tele-health provider who accepted my insurance	
97 Other	

Q2A3. Focusing on the single most important time when Care was sought but not received by you or a covered family member, what happened to you or your family member? Please select all that apply.

	Mental Health
01 Condition became worse	
02 Hospital admission	
03 Emergency room visit	
04 Job/employment impacted because of inability to work regular hours or work at all	
05 Lost job/employment	
06 Family life impacted due to inability to maintain job/same level of income	
07 Family life impacted due to increased stress among family members or other reasons	
08 No impact	
97 Other	

[Software Programmer: Ask Q2B1, Q2B2, and Q2B3 if respondent didn't receive Care for Substance Use Conditions (Q1 b. = 03 or 04)]

Substance Use Conditions

Q2B1. Focusing on the single most important time when Care was sought but not received by you or a covered family member, what level of Care was sought? Please select all that apply:

	Substance Use					
	Outpatient Services		Inpatient Services		Prescription Drugs	
	Urgent Care	Routine Care	Urgent Care	Routine Care	Urgent Care	Routine Care
Substance Use Conditions						

Q2B2. Focusing on the single most important time when Care was sought but not received by you or a covered family member, why was Care not received? Please select all that apply:

	Substance Use
01 Couldn't find an in-network provider in my area	
02 Could find an in-network provider in my area but they were not taking new patients	
03 Couldn't afford an in-network provider in my area	
04 Couldn't find an out-of-network provider in my area	
05 Could find an out-of-network provider in my area but they were not taking new patients	
06 Couldn't afford an out-of-network provider in my area	
07 My insurance plan would not pay for the provider I found and wanted to see	
08 The wait time to see an in-network provider was too long	
09 The wait time to see an out-of-network provider was too long	
10 I was not comfortable with the providers that I found, due to language, cultural or other factors	
11 My insurance plan did not cover Tele-health visits	
12 I did not have a device that supported video Tele-health, and my insurance plan did not pay for audio-only Tele-health (i.e., telephone call)	
13 My insurance plan covered Tele-health but I couldn't find a Tele-health provider who accepted my insurance	
97 Other	

Q2B3. Focusing on the single most important time when Care was sought but not received by you or a covered family member, what happened to you or your family member? Please select all that apply.

	Substance Use
01 Condition became worse	
02 Hospital admission	
03 Emergency room visit	
04 Job/employment impacted because of inability to work regular hours or work at all	
05 Lost job/employment	
06 Family life impacted due to inability to maintain job/same level of income	
07 Family life impacted due to increased stress among family members or other reasons	
08 No impact	
97 Other	

[Software Programmer: Ask Q2C1, Q2C2, and Q2C3 if respondent didn't receive Care for Medical/Surgical Conditions (Q1 c. = 03 or 04)]

Medical/Surgical Conditions

Q2C1. Focusing on the single most important time when Care was sought but not received by you or a covered family member, what level of Care was sought? Please select all that apply:

	Medical/Surgical					
	Outpatient Services		Inpatient Services		Prescription Drugs	
	Urgent Care	Routine Care	Urgent Care	Routine Care	Urgent Care	Routine Care
Medical/Surgical Conditions						

Q2C2. Focusing on the single most important time when Care was sought but not received by you or a covered family member, why was Care not received? Please select all that apply:

	Medical/ Surgical
01 Couldn't find an in-network provider in my area	
02 Could find an in-network provider in my area but they were not taking new patients	
03 Couldn't afford an in-network provider in my area	
04 Couldn't find an out-of-network provider in my area	
05 Could find an out-of-network provider in my area but they were not taking new patients	
06 Couldn't afford an out-of-network provider in my area	
07 My insurance plan would not pay for the provider I found and wanted to see	
08 The wait time to see an in-network provider was too long	
09 The wait time to see an out-of-network provider was too long	
10 I was not comfortable with the providers that I found, due to language, cultural or other factors	
11 My insurance plan did not cover Tele-health visits	
12 I did not have a device that supported video Tele-health, and my insurance plan did not pay for audio-only Tele-health (i.e., telephone call)	
13 My insurance plan covered Tele-health but I couldn't find a Tele-health provider who accepted my insurance	
97 Other	

Q2C3. Focusing on the single most important time when Care was sought but not received by you or a covered family member, what happened to you or your family member? Please select all that apply.

	Medical/ Surgical
01 Condition became worse	
02 Hospital admission	
03 Emergency room visit	
04 Job/employment impacted because of inability to work regular hours or work at all	
05 Lost job/employment	
06 Family life impacted due to inability to maintain job/same level of income	
07 Family life impacted due to increased stress among family members or other reasons	
08 No impact	
97 Other	

The following questions relate to instances when you or a covered family member **did receive** Care from a **new in-network** provider.

Q3. During the Survey Period, did you or a covered family member see at least one new in-network provider for Routine Care or Urgent Care. Please select all that apply.

	Saw at least one new in-network provider
a. Mental health conditions	
b. Substance use conditions	
c. Medical/surgical conditions	

[Software Programmer: For Q3A, only display the conditions that the respondent selected in Q3]

Q3A. During the Survey Period, in total, how many new in-network providers did you and covered family members see? Select one answer in each row:

1 new in-network provider	2 new in-network providers	3 or more new in-network providers

a. Mental health conditions			
b. Substance use conditions			
c. Medical/surgical conditions			

[Software Programmer: Ask Q3B1, Q3B2, Q3B3, and Q3B4 if respondent saw a new in-network provider for Mental Health Conditions (Q3 a. = true)]

Mental Health Conditions

Q3B1. Thinking of the single most important new in-network provider that you or a covered family member saw: What level of Care was received? Please select only one:

	Mental Health
Outpatient	
Routine	
Urgent	
Inpatient	
Routine	
Urgent	

Q3B2. In order to find this single most important new in-network provider, how many in-network providers did you or a covered family member have to contact before you/they were able to obtain an appointment with a new in-network provider? Please select only one:

	Mental Health
01 1 - 3 providers	
02 4 - 7 providers	
03 7 - 9 providers	
04 10 or more providers	

Q3B3. How long was it between the time you or a covered family member started searching for the single most important new in-network provider and when you/they were able to schedule an appointment? Please select only one:

	Mental Health
01 0 - 4 hours	
02 4 - 24 hours	
03 1 - 6 days	
04 Between 1 - 2 weeks	
05 Between 2 weeks - 1 month	
06 Between 1 - 2 months	
07 Over 2 months	

Q3B4. Once this single most important new in-network provider was found and an appointment was scheduled, what was the "wait time" until you/they actually saw the provider? Please select only one:

	Mental Health
01 0 - 4 hours	
02 4 - 24 hours	
03 1 - 6 days	
04 Between 1 - 2 weeks	
05 Between 2 weeks - 1 month	
06 Between 1 - 2 months	
07 Over 2 months	

[Software Programmer: Ask Q3C1, Q3C2, Q3C3, and Q3C4 if respondent saw a new in-network provider for Substance Use Conditions (Q3 b. = true)]

Substance Use Conditions

Q3C1. Thinking of the single most important new in-network provider that you or a covered family member saw: What level of Care was received? Please select only one:

	Substance Use
Outpatient	
Routine	
Urgent	
Inpatient	
Routine	
Urgent	

Q3C2. In order to find this single most important new in-network provider, how many in-network providers did you or a covered family member have to contact before you/they were able to obtain an appointment with a new in-network provider? Please select only one:

	Substance Use
01 1 - 3 providers	
02 4 - 7 providers	
03 7 - 9 providers	
04 10 or more providers	

Q3C3. How long was it between the time you or a covered family member started searching for the single most important new in-network provider and when you/they were able to schedule an appointment? Please select only one:

	Substance Use
01 0 - 4 hours	
02 4 - 24 hours	
03 1 - 6 days	
04 Between 1 - 2 weeks	
05 Between 2 weeks - 1 month	
06 Between 1 - 2 months	
07 Over 2 months	

Q3C4. Once this single most important new in-network provider was found and an appointment was scheduled, what was the "wait time" until you/they actually saw the provider? Please select only one:

	Substance Use
01 0 - 4 hours	
02 4 - 24 hours	
03 1 - 6 days	
04 Between 1 - 2 weeks	
05 Between 2 weeks - 1 month	
06 Between 1 - 2 months	
07 Over 2 months	

[Software Programmer: Ask Q3D1, Q3D2, Q3D3, and Q3D4 if respondent saw a new in-network provider for Medical/Surgical Conditions (Q3 c. = true)]

Medical/Surgical Conditions

Q3D1. Thinking of the single most important new in-network provider that you or a covered family member saw: What level of Care was received? Please select only one:

	Medical/ Surgical
Outpatient	
Routine	
Urgent	
Inpatient	
Routine	
Urgent	

Q3D2. In order to find this single most important new in-network provider, how many in-network providers did you or a covered family member have to contact before you/they were able to obtain an appointment with a new in-network provider? Please select only one:

	Medical/ Surgical
01 1 - 3 providers	
02 4 - 7 providers	
03 7 - 9 providers	
04 10 or more providers	

Q3D3. How long was it between the time you or a covered family member started searching for the single most important new in-network provider and when you/they were able to schedule an appointment? Please select only one:

	Medical/ Surgical
01 0 - 4 hours	
02 4 - 24 hours	
03 1 - 6 days	
04 Between 1 - 2 weeks	
05 Between 2 weeks - 1 month	
06 Between 1 - 2 months	
07 Over 2 months	

Q3D4. Once this single most important new in-network provider was found and an appointment was scheduled, what was the "wait time" until you/they actually saw the provider? Please select only one:

	Medical/ Surgical
01 0 - 4 hours	
02 4 - 24 hours	
03 1 - 6 days	
04 Between 1 - 2 weeks	
05 Between 2 weeks - 1 month	
06 Between 1 - 2 months	
07 Over 2 months	

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One Specified Plan in One Specified Region

Expand Implementation of the Collaborative Care Model ("CoCM")
Appendix for Model Language Section 2(a)
Volume of Allowed Collaborative Care Claims

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Plan _____ in Specified Region _____

Table 2(a)(i) - CoCM Data Reporting: In-Network Providers							
	In-network Providers	**CPT Code 99492**	**CPT Code 99493**	**CPT Code 99494**	**CPT Code 99484**	**HCPCS Code G2214**	**All Codes Combined**
(i)	The volume of claims paid to PCPs and to other eligible clinicians (combined) with respect to each of the following CoCM codes						
(ii)	Year over year growth rate in the volume of claims submitted by PCPs and by other eligible clinicians (combined) for the CoCM billing codes, with a target growth rate of 20% each year	%	%	%	%	%	%
(iii)	The number of significant healthcare providers (defined as a provider with at least 20 PCPs) that actively billed for any of the following CoCM codes						
(iv)	The percentage of significant healthcare providers (defined as a provider with at least 20 PCPs) that actively billed for any of the following CoCM codes	%	%	%	%	%	%
(v)	The number of unique patients for whom at least one CoCM code was paid						

Table 2(a)(ii) - CoCM Data Reporting: Out-of-Network Providers							
	OON Providers	**CPT Code 99492**	**CPT Code 99493**	**CPT Code 99494**	**CPT Code 99484**	**HCPCS Code G2214**	**All Codes Combined**
(i)	The volume of claims paid to PCPs and to other eligible clinicians (combined) with respect to each of the following CoCM codes						
(ii)	Year over year growth rate in the volume of claims submitted by PCPs and by other eligible clinicians (combined) for the CoCM billing codes, with a target growth rate of 20% each year	%	%	%	%	%	%
(iii)	The number of significant healthcare providers (defined as a provider with at least 20 PCPs) that actively billed for any of the following CoCM codes						
(iv)	The percentage of significant healthcare providers (defined as a provider with at least 20 PCPs) that actively billed for any of the following CoCM codes	%	%	%	%	%	%

(v)	The number of unique patients for whom at least one CoCM code was paid						

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One Specified Plan in One Specified Region

Expand Implementation of the Collaborative Care Model ("CoCM")
Appendix for Model Language Section 2(b)(i)
In-network Provider Reimbursement Indexed to Medicare for CoCM Codes

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Plan _____ in Specified Region _____

With respect to the CoCM CPT codes (99492, 99493, 99494, and 99484) and HCPCS code G2214, **reimburse PCPs at rates that are at a premium (relative to Medicare-allowed rates), with the premium being at least equivalent to the premium (relative to Medicare-allowed rates) paid to PCPs for CPT codes 99213 and 99214 (combined).**

The method of calculating these premiums is set forth in the tables below.

If the premium (relative to Medicare-allowed rates) for each CoCM code is not at least equivalent to the premium (relative to Medicare-allowed rates) paid to PCPs for codes 99213 and 99214 (combined), provide a **Plan of Correction.**

Table 2(b)(i) Part 1 - Premium Paid to PCPs for CPT Codes 99213 and 99214		
	Description	**CPT Codes 99213 & 99214, combined**
(x)	For the Plan Year, calculate the weighted average in-network allowed amount for PCPs for CPT codes 99213 and 99214, combined (weighted by the proportion of claims allowed for each of 99213 and 99214 at each allowed amount level*) (the "Weighted Average Plan Amount").	$
(y)	For the same Plan Year, using the National Medicare Fee Schedule allowed amounts for PCPs participating in Medicare for CPT codes 99213 and 99214, calculate the weighted average National Medicare Fee Schedule allowed amount (the "Weighted Average Medicare Amount"). Note: Although Medicare Fee Schedule allowed amounts are available by region, nonetheless use the National Medicare Fee Schedule allowed amount. For example, in 2020 the National Medicare Fee Schedule allowed amount for 99213 was $76.15 and for 99214 was $110.43. Therefore, the "Weighted Average Medicare Amount" relevant to a Specified Plan in a Specified Region in 2020 would be the weighted average of these two figures, with the weighting of $76.15 and $110.43 being the percentage of allowed PCP claims in that Specified Plan in that Specified Region with respect to codes 99213 and 99214, respectively.	$
(z)	Calculate the premium of the Weighted Average Plan Amount over the Weighted Average Medicare Amount, expressed as a percentage. For example: If the Weighted Average Plan Amount was $115 and the Weighted Average Medicare Amount was $100, then the premium was $115/$100 = 1.15 = 15%.	%

Table 2(b)(i) Part 2 - Premium Paid to PCPs for CoCM Codes						
	Description	**CPT Code 99492**	**CPT Code 99493**	**CPT Code 99494**	**CPT Code 99484**	**HCPCS Code G2214**
(x)	For the same year used in the table above, what was the in-network allowed amount for PCPs and other eligible clinicians for each of the following CPT codes?	$	$	$	$	$
(y)	For the same year, indicate the National Medicare Fee Schedule allowed amount for PCPs and other eligible clinicians for each of the following CPT codes. For example, in 2020 the National Medicare Fee Schedule allowed amounts for 99492, 99493, 99494, and 99484 were, respectively, $156.99, $126.31, $63.88, and $48.00.	$	$	$	$	$
(z)	Premium to Medicare-allowed rates paid to in-network PCPs and other eligible clinicians (Row x / Row y = ___ %)	%	%	%	%	%

Table 2(b)(i) Part 3 - Adequacy of Premium Paid Relative to Medicare for CoCM Codes					
Description	**CPT Code 99492**	**CPT Code 99493**	**CPT Code 99494**	**CPT Code 99484**	**HCPCS Code G2214**
Was the "premium to Medicare" for the CoCM codes at least as high as the premium for 99213 and 99214 (combined) (i.e., Is Row z in Table 2(b)i Part 2 at least as high as Row z in Table 2(b)i Part 1)? (Yes/No)					
If "No", was a **Plan of Correction** submitted and receipt acknowledged? (Yes/No)					
If "Yes", to whom was the **Plan of Correction** submitted?					

* This calculation will provide the same result as calculating the sum of the allowed amounts for each in-network 99213 and 99214 claim that was allowed for PCPs, and dividing that sum by the total number of such claims allowed for PCPs.

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One Specified Plan in One Specified Region

Expand Implementation of the Collaborative Care Model ("CoCM")
Appendix for Model Language Section 2(b)(ii)
Benefit Design Barriers: Member Out-of-Pocket Costs and Billing Code Limits

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Plan _____ in Specified Region _____

With respect to the CoCM CPT codes (99492, 99493, 99494, and 99484) and HCPCS code G2214, waive patient out-of-pocket costs**.** With respect to 99494, eliminate any limit on frequency of use.

If patient out-of-pocket costs were not waived, or if limits ~~are~~ imposed on the frequency of use of 99494 were not eliminated, provide a **Plan of Correction**.

Table 2(b)(ii) - Waiver of Patient Out-of-Pocket Costs and Elimination of Billing Limits for CPT 99494					
Description	**CPT Code 99492**	**CPT Code 99493**	**CPT Code 99494**	**CPT Code 99484**	**HCPCS Code G2214**
For CoCM, were patient out-of-pocket costs waived? (Yes/No)					
If "No", was a Plan of Correction submitted and receipt acknowledged? (Yes/No)					
If "Yes", to whom was the Plan of Correction submitted?					
For CoCM, were limits on the frequency of use of 99494 eliminated? (Yes/No)					

If "No", was a Plan of Correction submitted and receipt acknowledged? (Yes/No)					
If "Yes", to whom was the Plan of Correction submitted?					

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One Specified Plan in One Specified Region

Expand Implementation of the Collaborative Care Model ("CoCM")
Appendix for Model Language Section 2 (c)(i)
Provider Outreach: CoCM Information

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Plan _____ in Specified Region _____

(i) Highlight the effectiveness of CoCM and reach out to medical providers in the TPA's networks to inform them that the TPA is reimbursing for CoCM codes with the allowed amounts described above. (ii) Provide to [client] and [benefit consultant] copies of the information given to medical providers explaining and promoting CoCM. (iii) Identify barriers to adoption of the CoCM, such as the need for technical assistance.

Table 2(c)(i) - CoCM Information and Outreach		
(i)	Number of medical providers informed	
(ii)	Number of copies of information (given to medical providers) which were provided to [client] and [benefit consultant]?	
	What percentage of the time were copies provided to client or benefit consultant?	%
	To whom were copies of the information provided?	
(iii)	Identified barriers to adoption of CoCM	

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One Specified Plan in One Specified Region

Expand Implementation of the Collaborative Care Model ("CoCM")
Appendix for Model Language Section 2(c)(ii)
Provider Training and Technical Support

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Region _____

In all Specified Regions, promote implementation of CoCM by significant healthcare providers. **In one Specified Region, award training and a technical support grant to cover the cost of implementing and expanding use of the CoCM, as follows**: In each calendar year, award a grant for a minimum of $30,000 to at least one significant healthcare provider. Provide information on the identity of grant recipients and the amount of each grant, and indicate if grant recipient began to significantly utilize CoCM before year end. Note: It is anticipated that multiple TPAs will award grants in the Specified Regions and that a Regional Employer Coalition will assist in coordination of these awards.

If no grants were awarded or if no grant recipient began to significantly utilize CoCM by year end, provide a **Plan of Correction**.

Table 2(c)(ii) - Training and Technical Support			
	Grant Recipient	**Grant Amount**	**Significant Utilization of CoCM by year end (Yes/No)**
1		$	
2		$	
3		$	
4		$	
	Total	**$ -**	

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One Specified Plan in One Specified Region

Expand Screening for and Monitoring of MH/SUD with Measurement-Based Care ("MBC")
Appendix for Model Language Section 3(a)

HEDIS Reporting

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Plan _____ in Specified Region _____

Require commercial Accountable Care Organizations (ACOs) and other providers with value-based purchasing arrangements to report at least 2 HEDIS data measurements on effectiveness of care (these quality measures are already in use by Medicare ACOs), to include: (i) Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan, and (ii) Depression Remission at Twelve (12) Months. Provide a summary of adherence to this requirement.

Table 3(a) - HEDIS Reporting

	HEDIS Data Measurement	Number of Commercial ACOs* in this Specified Region	Percent of Commercial ACOs* in this Specified Region that regularly reported this HEDIS Data Measurement	Comments about Adherence to this Requirement by Commercial ACOs*
1	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan		%	
2	Depression Remission at Twelve (12) Months		%	
3			%	
4			%	
5			%	

* Refers to ACOs and other providers with value-based purchasing arrangements

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One Specified Plan in One Specified Region

Expand Implementation of Measurement-Based Care ("MBC")
Appendix for Model Language Section 3(b)

Demonstration of Written Support for MBC

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Urge, via written communication to URAC, The Joint Commission, NCQA and CARF, that MH/SUD MBC for both M/S and MH/SUD providers be required, and provide a summary of such written support.

Table 3(b) - Written support to require MH/SUD MBC for both M/S and MH/SUD providers				
	Quality Assurance Organization Name	**Did TPA provide a letter of support during this calendar year? (Yes/No)**	**If "Yes", did TPA send a copy of the letter of support to client? (Yes/No)**	**If "Yes", to whom was the copy of the letter of support submitted?**
1	URAC			
2	The Joint Commission			
3	NCQA			
4	CARF			
	Total Letters			

URAC
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[Insurer/TPA] supports the requirement of a Measurement Based Care (MBC) standard for accreditation of both behavioral health and primary care providers delivering care for mental health conditions and substance use disorders. MBC is the use of standardized and validated clinical rating scales on a repeated basis to screen for behavioral disorders and suicide and to guide treatment decisions.

[Insurer/TPA] appreciates URAC's leadership in creating an MBC Designation for URAC accredited or certified organizations and providers, yet *urges URAC to make the MBC Designation a required standard for accreditation or certification for both behavioral and non-behavioral medical providers* .

[Insurer/TPA] thanks URAC for its continued commitment to the incorporation of MBC in its accreditation and certification standards.

The Joint Commission (TJC)
Attn: Mark R. Chassin, President and CEO (mchassin@jointcommission.org)
David Baker, Exec. V. P. (dbaker@jointcommission.org)
Brian Enochs, Exec. V. P. of Business Development and Marketing (benochs@jointcommission.org)
Scott Williams, Director Health Services Research (swilliams@jointcommission.org)
cc: Accreditation Standards Interpretation Group
1 Renaissance Blvd
Oakbrook Terrace, Il 60181

[Insurer/TPA] supports the requirement of a Measurement Based Care (MBC) standard for accreditation of both behavioral health and primary care providers delivering care for mental health conditions and substance use disorders. MBC is the use of standardized and validated clinical rating scales on a repeated basis to screen for behavioral disorders and suicide and to guide treatment decisions.

[Insurer/TPA] appreciates The Joint Commission's (TJC's) revisions effective January 1, 2018 to Care, Treatment and Services (CTS) Standard CTS.03.01.09 for accredited behavioral health care organizations, requiring such organizations to assess outcomes by using a standardized tool or instrument (MBC). [Insurer/TPA] *urges TJC to require MBC standards for accredited non-behavioral medical providers as well as behavioral providers* .

[Insurer/TPA] thanks TJC for its continued commitment to the incorporation of MBC in its accreditation standards.

NCQA

Attn: Margaret E. O'Kane, President (okane@ncqa.org)
Tom Fluegel, Chief Operating Officer (fluegel@ncqa.org)
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[Insurer/TPA] supports the requirement of a Measurement Based Care (MBC) standard for accreditation of both behavioral health and primary care providers delivering care for mental health conditions and substance use disorders. MBC is the use of standardized and validated clinical rating scales on a repeated basis to screen for behavioral disorders and suicide and to guide treatment decisions. [Insurer/TPA] *urges NCQA to incorporate an MBC standard for both behavioral and non-behavioral medical providers as part of its accreditation requirements* .

[Insurer/TPA] thanks NCQA for its continued commitment to excellence in its accreditation standards.

CARF International

Attn: Brian J. Boon, President and CEO (bboon@carf.org)
Darren M. Lehrfeld, Chief Accreditation Officer and General Counsel (dlehrfeld@carf.org)
Penny Gagnon, Chief Advisor for Accreditation Standards (pgagnon@carf.org)
Michael W. Johnson, Mng Director of Behavioral Health Accreditation (mjohnson@carf.org)
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Tucson, AZ 85756-9407

[Insurer/TPA] supports the requirement of a Measurement Based Care (MBC) standard for accreditation of both behavioral health and primary care providers delivering care for mental health conditions and substance use disorders. MBC is the use of standardized and validated clinical rating scales on a repeated basis to screen for behavioral disorders and suicide and to guide treatment decisions. [Insurer/TPA] *urges CARF International to incorporate an MBC standard for both behavioral and non-behavioral medical providers as part of its accreditation requirements* .

[Insurer/TPA] thanks CARF International for its continued commitment to excellence in its accreditation standards.

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One Specified Plan in One Specified Region

Expand Implementation of Measurement-Based Care ("MBC")
Appendix for Model Language Section 3(c)

Promotion of MBC in Treatment of MH/SUD

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Plan _____ in Specified Region _____

Promote with all network MH/SUD and M/S providers the need to consistently use standardized symptom measurement tools for diagnosing and treating mental health and substance use disorders, such as the PHQ-9, GAD-7 and related validated tools, and provide data on the percentage of MH/SUD and PCPs consistently using such tools. Ask whether medical providers require technical assistance regarding the use of these instruments and provide data on the number of providers to which technical support was provided.

Table 3(c) - Promote MH/SUD MBC		
Description	**MH/SUD Providers**	**M/S Providers**
Number of providers to which TPA actively promoted the use of MH/SUD MBC		
Percentage of providers who consistently used standardized MH/SUD symptom measurement tools	%	%
Number of providers to which TPA offered MH/SUD MBC technical assistance		
Number of providers to which MH/SUD MBC technical assistance was provided		

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One Specified Plan in One Specified Region

Sustain Expanded Access to Tele-Behavioral Health ("TBH") Services
Appendix for Model Language Section 4(a)
TBH Coverage and Reimbursement

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Plan _____ in Specified Region _____

(i) In-network and out-of-network MH/SUD providers will be reimbursed for both audio-only and video treatment modalities for the delivery of TBH services. (ii) The allowed amounts for such services shall be the same as the allowed amounts for in-person office visits.

If (i) in-network and out-of-network MH/SUD providers were not reimbursed for both audio-only and video treatment modalities for the delivery of TBH services, or (ii) allowed amounts for such services were not the same as allowed amounts for in-person office visits, provide a **Plan of Correction**.

Table 4(a)i - TBH Coverage				
	In-Network		Out-of-Network	
Description	**Audio-only**	**Video**	**Audio-only**	**Video**
Were MH/SUD providers reimbursed for the following TBH treatment modalities? (Yes/No)				
If "No", was a Plan of Correction submitted and receipt acknowledged? (Yes/No)				

Table 4(a)ii - TBH Reimbursement				
	In-Network		Out-of-Network	
Description	**Audio-only**	**Video**	**Audio-only**	**Video**
Were the allowed amounts for the following TBH treatment modalities the same as the allowed amounts for in-person office visits? (Yes/No)				
If "No", was a Plan of Correction submitted and receipt acknowledged? (Yes/No)				

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One Specified Plan in One Specified Region

Sustain Expanded Access to Tele-Behavioral Health ("TBH") Services
Appendix for Model Language Section 4(b)
Tele-Behavioral Health Data Reporting

Name of TPA _____ Date Completed _____
Plan Year _____ Person Completing _____

Specified Plan _____ in Specified Region _____

	Table 4(b)(i) - TBH Spending and Allowed Claims Data			
	Description	**TBH Audio-only**	**TBH Video**	**In-person**
	The percentage of total MH and SUD non-facility based treatment services spending (for in-network and out-of-network services (combined), via CPT codes or via contracts with "third party TBH providers") that were for TBH audio-only, TBH video, and in-person services	%	%	%
	In-network			
	The volume of non-facility based claims allowed			
	The percentage of non-facility based claims allowed	%	%	%
	Out-of-network			
	The volume of non-facility based claims allowed			
	The percentage of non-facility based claims allowed	%	%	%

	Table 4(b)(ii) - In-network Reimbursement Information for non-facility based treatment services: Allowed amounts reimbursed for the 10 highest volume TBH codes					
	TBH CPT Code	**TBH Audio-only Allowed Amount**	**TBH Video Allowed Amount**	**Equivalent In-person CPT Code**	**In-Person Allowed Amount**	**Were both TBH Audio-only and TBH Video Allowed Amounts Equivalent to In-Person? (Yes/No)**
1		$	$		$	
2		$	$		$	
3		$	$		$	
4		$	$		$	
5		$	$		$	
6		$	$		$	
7		$	$		$	
8		$	$		$	
9		$	$		$	
10		$	$		$	
					Percentage of codes for which all three modalities used the same allowed amount	%

	Table 4(b)iii - Listing of which of the TPA's "third party TBH providers" were using MBC
	Provider's Name
1	
2	
3	
4	
5	
6	