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Taking Action Against the Rising Mental Health Crisis: Efforts From Health Plans, Congress, and More

Matthew Gavidia

The mental health crisis in the United States has shown staggering increases in rates of mood disorders and suicide-related outcomes among adults and adolescents. Along with COVID-19, issues such as social media use and the intensifying danger of climate change have been associated with symptoms of depression, anxiety, suicidality, and other psychiatric conditions, particularly among youth.

According to recent data from the CDC, more than a third of high school students reported experiencing poor mental health during the pandemic, and LGBT and female youth were disproportionately affected.

Moreover, research from a myriad of organizations, such as the National Alliance of Healthcare Purchaser Coalitions (National Alliance), Lyra Health, and Ginger, has only further distinguished mental health as an epidemic in vital need of nationwide intervention:

- 80% of US workers indicated in a poll by Lyra Health and the National Alliance that they were experiencing mental health issues during the early months of the pandemic.
- Nearly 7 in 10 employees indicated in a Ginger survey that the pandemic was the most stressful time of their entire professional career.
- An analysis by Blue Cross Blue Shield of Massachusetts showed that use of outpatient mental health services, including psycho-

SPOTLIGHT ON

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Biosimilar Utilization Increased During the OCM and Generated Savings

Laura Joszt, MA

Practices that participated in the Oncology Care Model and utilized biosimilars saw increased savings and reduced risk, according to 2 posters presented at the American Society of Clinical Oncology Annual Meeting.

One abstract from practices in The US Oncology Network reviewed the concerted approach to adopt biosimilars for the purposes of reducing total cost of care (TCOC).¹ Specifically, the authors, led by Lalan S. Wilfong, MD, vice president, payer relations and practice transformation at McKesson, which owns The US Oncology Network, analyzed claims

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data from 14 practices for performance period 8 (PP8) of the OCM.

PP8 ran from January 2, 2020, to July 1, 2020. The 6-year OCM has a total of 11 performance periods (PPs), with the final PP ending June 30, 2022. Currently, there is no replacement for the OCM planned.

Use of bevacizumab, trastuzumab, and rituximab biosimilars increased from previous PPs, they found. In PP6, biosimilar use for all 3 therapeutic classes was 0%, which increased modestly to 5% for bevacizumab biosimilars, 4% for trastuzumab biosimilars, and 2% for rituximab biosimilars in PP7. In PP8, there was significantly increase to 43% for bevacizumab biosimilars, 33% for trastuzumab biosimilars, and 41% for rituximab biosimilars.

The adoption of biosimilars resulted in \$6.61 million in savings compared with if the more expensive innovator drugs had been used entirely. They concluded that the increased utilization of biosimilars not only helped the practices in The US Oncology Network generate savings in the OCM, but it will increase savings to Medicare.

“We estimate that 100% Network adoption of these three biosimilars could save nearly 1.5% of the TCOC in our Network compared to continued use of innovator drugs,” they wrote.

The other abstract estimated the impact of biosimilar utilization on financial risk to providers in value-based payment (VBP) models.² They modeled the quantitative methodology of the OCM to apply a simulation approach to oncology VBP models. The authors,

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therapy, increased nearly 20% during COVID-19, and spending on substance use disorder treatment increased by 10%.

At the community level, these concerns have garnered expansive initiatives from employers and those involved in health benefit design, who have largely had to play catch up to fill the gaps of inadequate mental health coverage cited just before the pandemic began.

However, Michelle Thomas, LCSW, associate vice president, Behavioral Health, UPMC Health Plan, highlighted in an email exchange with *The American Journal of Managed Care*® (AJMC®) that there remain significant barriers continuing to limit the integration of behavioral health care services in the United States.

“Integrated behavioral health care, to me, is the blending of care into one setting for medical and behavioral health. In a more fully integrated practice, there may be a care team that consists of the primary care provider, a behavioral health clinician, and a consulting psychiatrist,” she explained.

Thomas noted that despite pockets of great success in behavioral care integration, barriers such as the lack of assessment for behavioral health conditions, inability to link at-risk patients with behavioral health care, and reimbursement models continue to widen the access gap practice by practice and state by state.

“Funding for [an integrated model] is often a challenge....Securing funds for a behavioral health clinician in the practice and/or a consulting psychiatrist can be difficult. It’s important to have engaged primary care practice leadership who are willing to dedicate resources to build an integrated model,” said Thomas.

“Care needs have increased, but patients are having a difficult time finding providers with openings in their schedule. Appointment wait times are longer than they were prior to COVID-19, and though telehealth has certainly helped with that, access needs persist, for all people, not just at-risk populations.”

Ellen Beckjord, PhD, MPH, vice president, Population Health and Clinical Optimization, UPMC Health Plan, discussed with AJMC® what beneficiaries should expect from their respective single/family health plans in meeting the behavioral health care needs of people nationwide.

In designing behavioral health care programs at the community level, Beckjord stressed the need for respective health plans to place greater value on what the community needs, prefers, and values, rather than their own interests, to build a partnership on a foundation of trust.

“Beneficiaries should expect that their health plans will offer evidence-based services in a variety of modalities that make receipt

of behavioral health care convenient and affordable, and beneficiaries should expect that health plans will architect their offerings in ways that improve health equity and ensure the most vulnerable have sufficient support to receive the care and services they need,” she added.

Echoing sentiments from Thomas, Beckjord cautioned that the threat of a “digital divide” may impede the widespread use of telehealth for behavioral health care needs. But use of digital tools, as well as new models of care and advances in pharmacological options, still show promise to provide robust and safe virtual communities for the provision and receipt of peer support, she said.

Along with health equity concerns, efforts to address stigma associated with behavioral health and receipt of treatment were also mentioned.

“Because the pandemic was a universal stressor, there’s been some positive impact on destigmatizing mental and behavioral health concerns; however, we have a long way to go to truly eliminate stigma and the disproportionate ways stigma affects those who are already vulnerable, thereby exacerbating inequity,” noted Beckjord.

“Keeping behavioral health in the shadows doesn’t protect us from shame and embarrassment, it robs us of opportunities to observe—and celebrate—our resilience. Making real changes regarding how we approach mental health challenges won’t expose our weaknesses—it will expose our strengths.”

Novel initiatives to address mental health have also found their way to Congress who recently introduced the 988 Implementation Act. Set to take effect July 16, 2022, at least 11 states have enacted legislation to fund and implement 988, a 3-digit designated hotline for people experiencing a mental health crisis to speak with trained counselors part of the established National Suicide Prevention Lifeline network.

Margie Balfour, MD, PhD, chief clinical quality officer, Connections Health Solutions, and practicing psychiatrist, spoke with *AJMC*[®] on the preventive impact that 988 will have on managing the growing mental health crisis.

“Having a 3-digit number like 988 makes it easier and less stigmatizing to ask for help. It sends the message that a mental health crisis is a legitimate health emergency like other kinds of emergencies. And most importantly, it connects the individual to someone who can provide clinical assessment and intervention,” she said.

Moreover, Balfour explained its potential implications for minority communities who may have been discouraged to call 911 for mental health emergencies in the past due to the involvement of law enforcement. Nearly a quarter of all people killed by police officers in America

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led by Jingyan Yang, MHS, DrPH, of Columbia University, examined bevacizumab, rituximab, trastuzumab, epoetin alfa, filgrastim, and pegfilgrastim.

They determined that substituting biosimilars for the originator reduced cost relative to target by a mean of \$1200 per eligible episode and the proportion of practices that were above benchmark for eligible episodes was reduced by 33%. The number of practices below target for eligible episodes was reduced by 42% because of biosimilar substitution.

However, these numbers are based on the assumption that substitution of chemotherapy drugs only occurred in patients who were treatment naïve. When the model was changed to remove this assumption, cost savings relative to target increased to \$2700 per eligible episode.

“Biosimilar substitution significantly reduces aggregate provider risk in OCM, representing a significant potential intervention for providers to mitigate risk in oncology VBPs both in terms of absolute costs saved relative to target and reduction in risk band relative to payer projections,” the authors concluded. ■

Reference

1. Wilfong LS, Indurlal P, Dominguez K, et al. Financial impact of biosimilar adoption in the oncology care model for the U.S. Oncology Network. Presented at: ASCO 2022; June 3-7, 2022; Chicago, Illinois. Abstract e18749.
2. Yang J, Chaudhry BI, Yue A, et al. Projected impact of oncology biosimilar substitution from the perspective of provider risk in value-based oncology payment models. Presented at: ASCO 2022; June 3-7, 2022; Chicago, Illinois. Abstract e18836.

have been shown to have had a known mental illness, with the risk of death magnified 10-fold for people of color.

Understanding how 988 will be implemented in each respective community will be of utmost importance for local stakeholders, providers, and advocacy groups, noted Balfour, as the hotline will be used primarily for suicide-related concerns in some communities, whereas in other areas, 988 will connect to a crisis line that provides access to dispatch mobile teams and crisis stabilization facilities.

“In addition to telephonic counseling, callers will need a similarly robust crisis system with mobile crisis teams to respond instead of police and specialized crisis stabilization facilities where people can receive care they need instead of boarding in emergency rooms. We need to build that crisis system of care and that will take time,” she said.

As the rollout of a national mental health crisis hotline will influence demand in psychiatric services, the lack of an adequate emergency response infrastructure in some communities may continue to direct patients to emergency rooms that are poorly equipped to manage mental health emergencies.

To assist in the rollout of the 988 hotline, Colin LeClair, CEO of Connections Health Solutions, said in an email exchange with *AJMC*® that there are several things hospitals and health systems, as well as health plans and insurance companies, can do to encourage the development of a high-functioning continuum of psychiatric care.

With many hospitals and health systems likely to be caught off guard by the increase in behavioral health care demand, LeClair said that what hospitals should do is work together with government agencies, community stakeholders, and competitive health systems in their communities to develop a high-performing center of excellence for emergent and urgent psychiatric care.

As opposed to competing to hire scarce mental health professionals to staff their emergency departments, which will still result in insufficient coverage for mental health emergencies, the design of a center of excellence that can provide high-quality, interdisciplinary psychiatric care, at scale, and supports all patients and all of those health systems agnostically, was touted by LeClair.

Furthermore, he cited 3 strategies for health plans and insurance companies in the rollout process:

1. Plans should cover crisis services equally—currently, original Medicare and most Medicare Advantage plans don’t cover many urgent and emergent crisis services, and commercial plans provide spotty coverage. These services are principally available to Medicaid-eligible populations, leaving most of the population with very few options if they’re in a psychiatric emergency.
2. Plans can help standardize the metrics that we use to measure quality and access, and the expected outcomes from each service, to ensure that we don’t increase the volume of services at the expense of quality.
3. Plans should insist on contracting with providers through value-based payment models that incentivize improved quality, access, patient experience, and sustainability so that new mental health services always put the patient first and do so in a sustainable, cost-effective way for the long-term viability of the mental health system.

Ultimately, optimizing an integrated approach to mental health and physical health management will reap significant benefits for employers and those involved in health benefit plan design. Currently, the greatest source of waste for health plans is in inpatient care, where nearly 40% of every behavioral health dollar is spent.

“Of course, our number one priority should be to improve timely access to preventive outpatient psychiatric care. But doing so requires a long-term workforce development strategy. In most markets, it also requires that significantly more funding be directed to those services,” said LeClair.

Nearly 70% of inpatient admissions can be replaced by high-quality emergent or urgent psychiatric care, at a fraction of the cost and with far better outcomes for patients, he added, which include lower readmission rates, better medication adherence, better primary care, and psychiatric outpatient care engagement following the mental health crisis.

“This is how we achieve all of the critical aims of a modern mental health system—improved access, quality, cost, patient experience, and sustainability.” ■

Integrating Analytics With High-Touch Pharmacy Care for Vulnerable Beneficiaries

Allison Inserro

How can high-touch pharmacy care management, enabled by analytics and technology, improve health and lower costs when caring for dual eligibles in Medicare Advantage (MA) and managed Medicaid?

At a session at the Pharmacy Quality Alliance 2022 Annual Meeting in Baltimore, Maryland, UPMC Health Plan, owned by the University of Pittsburgh Medical Center (UPMC), RxAnte, and Mosaic Pharmacy Services, outlined how they are operating a value-based pharmacy care management program within Community HealthChoices, Pennsylvania's managed Medicaid long-term services and supports (LTSS) program.

RxAnte, an analytics firm that is an independent company within UPMC Enterprises, uses predictive analytics to manage medication use; in 2019, it launched Mosaic Pharmacy Service, which assesses the medication regimens of at-risk patients, conducts medication reviews, examines adherence pitfalls, and delivers the medication sorted by day and time.

The trends in MA show why more intensive pharmacy care management is needed, according to Patricia Powers, PharmD, BCPS, director of clinical services at Mosaic.

The number of individuals in special needs plans have more than tripled since 2010, with a higher number of beneficiaries with chronic or disabling medical conditions, she said, and accounting for a higher proportion of health care spending. At the same time, there is an increase in medication waste, estimated by one study to be about \$528 million per year.

Traditional fee-for-service models don't allow for "our ability as pharmacists to provide services such as patient counseling, follow up and created limited opportunity for comprehensive medication reviews," Powers said.

Not every CHC participant is referred to their service, she

said—using analytics, they focus on those who have quality care gaps and unplanned care visits.

These members have to be interested in the service, at which point they are onboarded via phone. Medications are reconciled and Mosaic also identifies issues related to social determinants of health. Members are contacted every month and pharmacists are checking to see if any care transitions have happened, such as after a hospitalization. They also coordinate with providers, Powers said.

"Most of our patients have between 10 and 25 medications, and you can imagine that usually results in 3 or 4 prescribers," she said.

As an example of their service, Powers presented a case of a beneficiary, aged 71, who otherwise would not have qualified for a traditional medication therapy management program, as she was taking just 6 prescriptions: aripiprazole 2 mg QHS; duloxetine 60 mg 2 capsules QD; potassium chloride 10 meq QD; gabapentin 100 mg 2 capsules TID; clonazepam 1.5 mg QD; and hydroxyzine 50 mg BID prn.

She was low income, lacked transportation, did not have a high level of education, and she had treatment-resistant depression, generalized anxiety disorder, sciatic nerve pain, and hypokalemia.

"Not any of your chronic disease states that we typically think of who need this type of service," Powers said

Despite those issues, she was responsible for caregiving for her 4-year-old grandchild, and reported dizziness, sleepiness, confusion, and had had 1 recent fall. She had adherence issues with the clonazepam and the duloxetine and had not seen her psychiatrist in some time due to the pandemic and a lack of transportation.

Mosaic coordinated with the psychiatrist, who saw her via telehealth, and the dosages for duloxetine and hydroxyzine were reduced. She was also advised on how to take clonazepam appropriately.

The changes meant less anxiety and greater alertness for the patient, who reduced 3 medication dosages, and the health plan saved \$300.

Overall, the company's analysis of client data show that when comparing high-risk beneficiaries enrolled in Mosaic with matched controls, there is a savings of \$426

per member per month, mostly from reduced, unplanned hospitalizations and emergency department visits. The percent of members who are adherent to their medications were also higher—11% for diabetes medications, for example, and 18.1% for blood pressure medications.

In a question-and-answer session after the presentation, Vanessa Campbell, PharmD, senior manager of pharmacy services at UPMC, was asked what spurred them to look at these members more closely.

If they are in and out of the hospital frequently, she said, “what we see in talking to some of these patients is, they’re coming home, and they’re extremely overwhelmed, because they have their stocked meds still on the counter, they have new medications that have to be picked up, and frequently, we will see some of these members that don’t have a caretaker and they don’t have family support.”

Powers added that the lack of social support means that “oftentimes, our calls are longer than a traditional interaction, because we are providing some social support.... We often get involved in things that have nothing to do with the medication regimen.” ■

Biden Administration May Make a Push for Health Care Priorities Ahead of Midterms

Laura Joszt, MA

Coverage, equity, and value-based payments are critical areas of focus for the Biden administration’s health care agenda leading up to the midterm elections, according to 3 experts from Avalere, who gave one of the final presentations at Asembia’s Specialty Pharmacy Summit, held May 2-5 in Las Vegas, Nevada.

During the 2022 State of the Union address, President Biden had laid out his health care agenda and the priorities, explained Ryan Urgo, managing director, Avalere, and those items were:

- Allowing HHS to negotiate drug prices, which remains at the forefront
- Making the enhanced Affordable Care Act (ACA) premium subsidies set to expire at the end of this year permanent
- Securing funding for pandemic-related activities
- Focusing on cancer research through the reignited Cancer Moonshot initiative
- Tackling health equity, which is a theme throughout the priorities

Another area of focus is passing a so-called “skinny” version of the Build Back Better Act (BBBA), which the Senate failed to pass. “The tortured BBBA conversations are now emerging in a narrower context,” Urgo explained.

Part of the reason for a skinny BBBA is because the administration is feeling pressure to secure a big win in the run up to the midterm election after taking a beating on a number of other issues, including inflation.

ACA premium subsidies are likely to be included in the skinny BBBA. Currently, these enhanced subsidies, which were enacted as part of COVID-19 relief legislation, are set to expire at the end of the year, and premiums will go up. What’s more, the announcements about premium hikes will come out in September or October, right ahead of the midterm elections.

According to Urgo, Democrats want to avoid unwelcome commercials about premium increases ahead of what is already going to be a difficult midterm election. They may enact a temporary or permanent extension.

Climate policy is also likely to be included in the skinny BBBA because there is broad consensus around it. In addition, tax changes that rollback the corporate and individual tax cuts of the Trump administration will probably be part of the bill.

Finally, drug pricing will be another part of the skinny BBBA. “The political popularity of drug pricing can’t be understated,” Urgo said. So, that continues to be at the forefront of an emerging deal.”

The drug pricing priorities in a skinny version of the bill are likely to be Medicare negotiation, inflation-based rebates, and a Part D redesign. This deal will need to focus on the hold-out senators, and specifically, Senator Joe Manchin,

D-West Virginia, has said he sees a path for a deal, but he wants a focus on inflation with all revenue raised to be dedicated to a deficit reduction.

It's hard to know whether or not this deal can get done, but Urgo and his colleagues think talks have begun in earnest, although they won't be publicized much. However, there is limited time to get this done. According to Urgo, if nothing happens by Memorial Day, it may be getting too close to the midterms and then things will shut down and it will become a lame duck session.

However, work may begin to heat up through the Center for Medicare and Medicaid Innovation (CMMI), "which has been a bit quiet of late."

According to Lance Grady, practice director, market access, Avalere, although CMMI has been quiet, there has been indication of the perspectives of where the center wants to focus. He noted that CMMI Director Liz Fowler, PhD, JD, came from the Obama administration, when the ACA and CMMI were created. There is a focus on episodic payment reform and total cost of care.

If no legislation is finalized by Memorial Day and Congress moves into a lame duck session, "we expect CMMI to pick that baton up and start to test value-based coverage and value based assessments in a more holistic way," Grady said.

One of the most successful models out of CMMI has been the Oncology Care Model (OCM), although it is set to expire without a successor in place. Grady is hoping to see CMMI advance a model that builds on OCM, although how it will address biosimilars, drug pricing, and health equity remains to be seen.

In addition to equity being a big area of focus for CMMI and the Biden administration, insurers have identified promoting equitable outcomes through benefit design as a key priority, said Neil Lund, senior consultant, Avalere.

The challenge is that equity is a new issue to be tackled and "there's no roadmap," he said. Without a roadmap to build on, addressing health equity will happen through baby steps and incremental programs.

"There is no road map [for health equity]," he said. "No one really knows what we're doing."

Experts Discuss Driving Health Equity, Increasing CMS, ACO Alignment

Gianna Melillo

In the opening session of this year's National Association of Accountable Care Organizations (NAACOS) Spring Conference, NAACOS president and CEO Clif Gaus, ScD, moderated a discussion with Rob Fields, MD, MHA, chief population health officer at Mount Sinai Health System, and Meena Seshamani, MD, PhD, deputy administrator and director, Center for Medicare, CMS.

Throughout the session, both panelists and audience members stressed the importance of the incorporation of health equity into ACOs, while Seshamani offered insights on how the Biden administration plans to improve alignment between Medicare, models, and the organizations.

This year also marks the 10th anniversary of the Medicare Shared Savings Program (MSSP), and despite the fact that "the transition to [value-based care] remains very strong," more work needs to be done to meet the Center for Medicare & Medicaid Innovation's goal of having every Medicare beneficiary enrolled in an ACO by 2030, Gaus said.

"We've benefitted from a decade of lessons and commitment and awfully hard work driving transition to value-based care," he noted. But "it does not come easy, and it does not come fast."

Working with the administration and CMS to make changes in the accountable care model will be crucial to meeting the 2030 goal, Gaus said, adding that accelerating growth with private payers and solidifying primary care as the foundation for whole person care will be paramount in this effort.

Seshamani's appointment to director of the Center for Medicare also marks a step forward, as she is the first person in the position in a decade to have prior experience in value-based payment; she previously served as vice president at MedStar Health, where she led care transformation.

Advancing health equity, driving innovation, and ensuring affordability and sustainability in care are all central to Medicare's current mission, according to Seshamani.

“The promise of these holistic care models of transforming care on the ground to really enable and drive all 3 of those pillars that form the basis of the future of Medicare and the vision of Medicare, it is so critical for us [Medicare and ACOs] to partner together to cocreate that,” she said.

Creating synergy between CMS and CMMI to align models and allow for upscaling of successful models is also top of mind for Seshamani, who throughout the session reiterated her interest in hearing from ACOs on opportunities for improvement.

Increasing awareness of the benefits of these models, sharing best practices, and receiving input from patients can help ACOs and CMS achieve the 2030 goal, while concurrently serving to sway opinions of those still skeptical of the transition to value-based care.

Touching on an article published this week in *The New England Journal of Medicine* by Seshamani and colleagues, Gaus noted the data on the benefits of ACOs are clear, as the article included research that showed quality metrics for providers in MSSP ACOs were superior to those in the Merit-based Incentive Payment System (MIPS).

“Health care is very complex and very personal,” Seshamani said, noting these 2 factors offer a challenge and an opportunity for promoting care transformation. “Being able to share how the work that we do impacts the lives not only of the direct person you’re caring for, but their families, their communities,” can help sway naysayers, she noted.

With regard to using alternative payment models and ACOs to drive equitable outcomes in the Medicare population, Seshamani underscored the importance of addressing this mission in health care operations.

“We need to make sure that our health care system is navigable, has comprehensive care, is reliable,” she said. “That, in and of itself, will help advance equity, just having a really strong focus on it in our everyday work.”

Operations of ACOs, as holistic care models, can and do play a big role in driving navigable care and equity, with a focus on moving care upstream to address social determinants of health (SDOH), she added.

Along these lines, supporting providers in rural or underserved areas to engage in models is crucial, and CMS is doing

this by working alongside additional agencies like the Health Resources and Services Administration and the Administration for Children and Families, she said. By working with these agencies that have a hand in community outreach, CMS can better incorporate social services into care.

An additional challenge faced by the transition to value-based care is the overall lack of data collected on SDOH and challenges in testing whether equitable outcomes are being achieved, said Fields.

“It seems like government can play a couple roles; one is an enabler and incentivizer, if you will, to do that work. But also in opening up the masses of data, the government has to help understand our population better.”

With regard to incentivizing participation in ACOs, several hurdles exist, including statute-dictated time limitations on bonus payments. To address this roadblock, Seshamani cited CMS’ multipronged approach to working with ACOs to better understand and incorporate appropriate benchmarks and flexibilities.

However, one additional concern in model participation, where incentivization is based upon quality metrics, lies in the fact that providers or practices serving a majority-Medicaid population are judged on the same level as those serving more commercially insured patients, Fields noted.

This may “worsen disparities in the value-based movement because you’re disadvantaging those that take care of a higher number of Medicaid patients,” he said. “It is knowable, now, that closing a gap for a Medicaid patient is not the same as closing a gap for someone with commercial insurance.”

Similar issues are raised with regard to rural practices’ participation in ACOs, a problem commonly referred to as the “rural glitch.”

In response to these concerns, Seshamani stressed Medicare is actively working to better engage with ACOs and address problems from a joint perspective.

“Our eyes are open, our ears are open, and we are incorporating all of this information and exploring options here,” she said. “We want to grow these models, and we know that there is decision-making that goes on in determining engagement in these models, and it is a multifaceted decision.” ■