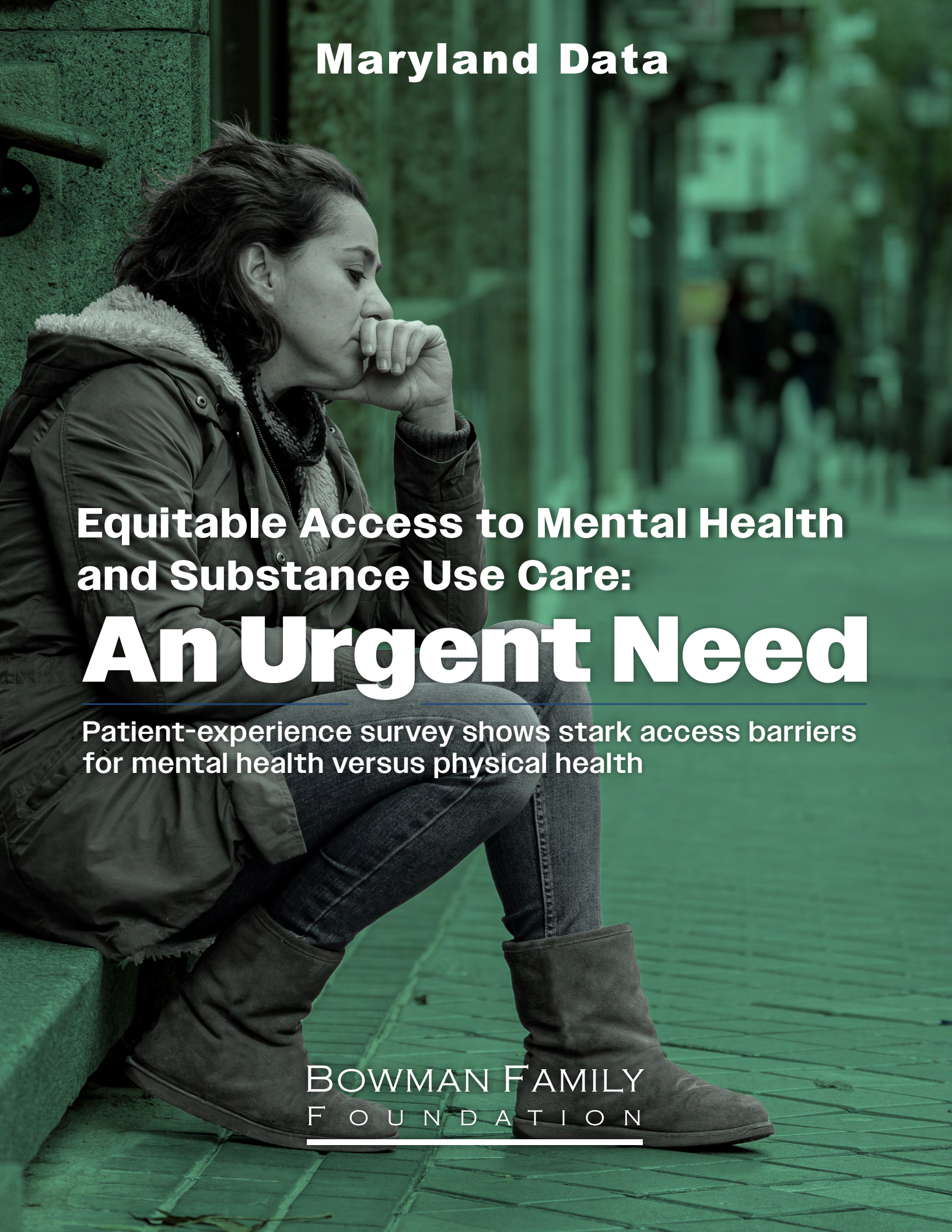

Maryland Data

Equitable Access to Mental Health and Substance Use Care: An Urgent Need

Patient-experience survey shows stark access barriers for mental health versus physical health

Bowman Family Foundation

Summary of Maryland Data from Survey Conducted by NORC

NORC, an independent, non-partisan research institute at the University of Chicago, conducted a survey of patients in order to understand their experiences in accessing mental health and/or substance use care (the "Survey"). NORC obtained IRB approval for the Survey and operated under a Certificate of Confidentiality from the National Institutes of Health. All numerical data below related to Survey responses was prepared by NORC or derived directly from numerical data prepared by NORC.

The Survey and related Report were funded by the Mental Health Treatment and Research Institute LLC, a tax-exempt subsidiary of The Bowman Family Foundation.

The Survey used convenience sampling across 26 behavioral health consumer organizations and behavioral health provider groups that distributed the NORC Survey link to their members, visitors, and followers via email, website, and/or social media at various periods between December 2021 and April 2022. In total, 2,794 responses to the Survey were received from patients who needed care between January 2019 through April 2022. They had a wide range of insurance types (commercial, Medicaid, Medicare, etc.).

Below are results for all respondents to the survey and, separately, respondents from Maryland. The total sample size of Maryland respondents was 246. Certain questions are not shown due to the sample size of Maryland respondents.

Multiple studies, including analyses of insurance claims and surveys of employers and providers, have demonstrated that in-network health insurance coverage for treatment of mental health and substance use conditions remains inadequate and not "on par" with access to in-network health insurance coverage for physical health treatment. The Survey found the same, as shown in the data below.

Gender	**All Respondents**	**Maryland Respondents**
Male	36%	30%
Female	61%	66%
Transgender	2%	1%
Do not identify as male, female, or transgender	2%	3%
Race		
White	82%	72%
Black or African American	9%	23%
Asian	3%	2%
All others	6%	3%
Hispanic Origin		
Yes	7%	5%
No	93%	95%
Age		
Under 18	6%	8%
18-21 years	6%	5%
22-26 years	11%	7%
27-54 years	57%	57%
55-64 years	13%	14%
Over 65 years	8%	9%

Types of Insurance	All Respondents	Maryland Respondents
Employer-Sponsored Plan	47%	39%
Private insurance purchased as an individual (including healthcare.gov)	6%	5%
Medicaid	17%	24%
Medicare	12%	14%
TRICARE	1%	1%
Federal Employee Health Benefits Program (FEHBP)	2%	5%
State or local government employer insurance	10%	8%
VA health benefits	1%	0%
Student health plan	1%	1%
Other	2%	2%

	All Respondents		Maryland Respondents	
Key Survey Findings	**MH/SUD***	**Physical Health**	**MH/SUD***	**Physical Health**
Percentage of patients using health insurance who received outpatient care from an in-network provider but had to contact 4 or more in-network providers before they were able to obtain an appointment with a new in-network provider	40%	14%	55%	16%
Percentage of patients using health insurance who received outpatient care from an in-network provider but had to contact 10 or more in-network providers before they were able to obtain an appointment with a new in-network provider	10%	1%	11%	1%
Percentage of patients who said that over 2 months elapsed between the time they started searching for a new in-network provider for outpatient care and when they were able to schedule an appointment	20%	11%	28%	15%
Percentage of patients in employer-sponsored health plans who used at least one out-of-network provider for outpatient care**	39%	15%		
Among patients in employer-sponsored health plans who received outpatient care from at least one out-of-network provider, percentage who said they went to an out-of-network provider “all of the time”**	80%	6%		
Percentage of patients with individual private insurance plans who used at least one out-of-network provider for outpatient care**	43%	19%		
Among patients with individual private insurance plans who received outpatient care from at least one out-of-network provider, percentage who said they went to an out-of-network provider “all of the time”**	47%	9%		
Percentage of patients with all insurance types combined who used at least one out-of-network provider for outpatient care**			33%	12%
Among patients with all insurance types combined who received outpatient care from at least one out-of-network			70%	5%

provider, percentage who said they went to an out-of-network provider "all of the time"**					
	All Respondents			**Maryland Respondents**	
Key Survey Findings (cont.)	**MH/SUD***	**Physical Health**		**MH/SUD***	**Physical Health**
Percentage of all patients who received mental health or substance use care from physical health providers who felt that they needed additional help from a mental health or substance use specialist	87%			96%	
Percentage of patients who said that, overall, they had problems with their health insurance plan denying coverage for mental health and/or substance use care based on either (1) the care not being medically necessary or (2) the care being not covered or excluded from coverage	65%			69%	
Percentage of patients who never used their health insurance to pay for outpatient care during the survey period	14%	2%		15%	3%
Percentage of patients who reported that their health condition worsened during the COVID-19 pandemic	76%	50%		76%	51%
Of patients who reported that their health condition worsened during the COVID-19 pandemic, percentage who reported that their condition became **"**much worse**"**	42%	24%		43%	22%
Percentage of patients who said in-person care is more beneficial than tele-behavioral health	50%			52%	
Percentage of patients who said in-person care and tele-behavioral health are similarly beneficial	38%			36%	
Percentage of patients who said tele-behavioral health is more beneficial than in-person care	12%			12%	
Percentage of patients who said that using interactive tele-behavioral health involving a provider helped	72%			73%	
Percentage of patients who preferred video tele-behavioral health as compared to audio	63%			57%	
Percentage of patients who preferred phone calls (audio only) or had no preference between video and phone calls	27%			33%	
Percentage of patients who said that they probably or definitely would use texting to interact with mental health or substance use providers	48%			50%	
Percentage of patients who said that using behavioral health smartphone or computer apps helped	64%			72%	
Percentage of patients who said it would be helpful if there was an objective information source that could tell them what behavioral health smartphone or computer apps have actually been effective for people like them	78%			81%	
Percentage of patients who said it would be helpful if their insurer would pay for a range of tele-behavioral health smartphone or computer apps, and they (or their provider) could select from a broad list that has been shown to help many people	85%			89%	

* MH/SUD = Mental Health/Substance Use Disorder

** Note that "all respondents" data ranks out-of-network use by employer plans and individual plans whereas state data looks at all insurance types combined, so the data isn't directly comparable.

In the Report, the authors provided context from several other studies and recommendations regarding near-term solutions.

Expand mental health and substance use networks: Add appropriately credentialed mental health and substance use providers of all levels of care to commercial, Medicaid and Medicare networks, through proactive network recruiting efforts driven by dedicated network expansion teams; fast tracking credentialing and other network admission requirements for all mental health and substance use providers; increasing reimbursement rates wherever shortages of in-network mental health and substance use providers exist; and decreasing unpaid hours of work by reducing administrative burdens such as pre-authorizations and retrospective claims audits. Using independent third parties, insurers should implement auditing of (i) the accuracy of their behavioral network directories (e.g., using secret shopper surveys) and (ii) compliance with their network adequacy standards.

Integrate mental health services into primary care using clinically effective methods: There are several evidence-based methods of integrating mental health and substance use care into primary care, such as the Collaborative Care Model (CoCM) and Primary Care Behavioral Health Model (PCBH). Both models improve mental health outcomes for patients (relative to treatment as usual in primary care) by involving a behavioral health specialist (such as a psychologist, social worker, or psychiatrist) who supports primary care providers. In CoCM, the primary care provider (PCP) is supported by a behavioral health care manager, who becomes part of the primary care team, and a virtual psychiatric consultant who advises both the treating PCP and the behavioral health care manager on effective use of psychotropic medications and other care topics. The clinical effectiveness of CoCM, and its ability to reduce the need for separately delivered specialty behavioral care, is supported by a substantial evidence base that includes more than 80 randomized trials and endorsements by 18 leading medical, business and non-profit organizations.

To expand availability of integrated care models to all Americans: 1) insurers should provide training and financial support to enable primary care to implement evidence-based integrated care; 2) all states should turn on Medicaid payment codes for CoCM and general behavioral health integrated care (BHI care) including G0323; 3) state Medicaid agencies should pay at least Medicare rates for CoCM and BHI codes; 4) commercial insurers should pay well above Medicare for CoCM and BHI codes; 5) commercial insurers (and ultimately Medicare and Medicaid) should eliminate or reduce patient out-of-pocket expenses for CoCM, PCBH, and other methods of integration.

It is important to note that use of both CoCM and BHI codes requires providers to screen and systematically assess patients using validated clinical rating scales.

Cover and pay for video and audio-only mental health services, at parity with in-person care: Evidence exists that, for many of the most common behavioral health conditions, tele-behavioral care is effective (See Lazur, et al. and Varker, et al.). Accordingly, insurers should provide coverage, with equivalent reimbursement, for in-person and tele-behavioral visits (video and phone calls) as was sometimes done during the worst of COVID-19. Even though tele-behavioral services may not replace all types of mental health and substance use care (e.g. inpatient programs, some intensive outpatient programs, and clinically complex cases), for many—especially those most vulnerable— tele-behavioral may be the only realistic option.

The results of the Survey indicate higher than average preferences among Medicaid and Black/African American patients for audio-only tele-behavioral care. Future research will determine if there are

significant differences (in terms of both clinical efficacy and patient preferences) between audio-only, video, and in-person sessions for other sub-populations in order to ensure that evidence guides regulations and insurer practices regarding tele-behavioral services.

Fully comply with and enforce federal and state parity laws: The volume of evidence showing disparities between access to mental health and substance use care versus physical health care from this Survey and prior studies underscores the importance of full compliance with and enforcement of federal and state parity laws.

We urge the Departments of Labor, Health and Human Services and the Treasury to finalize additional guidance on detailed templates for Mental Health Parity and Addiction Equity Act (MHPAEA) compliance data reporting as guidance to employer group plans, third party administrators and insurance issuers, indicating what data they should be prepared to submit upon request.

While a number of health plans are beginning to implement one or more of the solutions set forth above as a way in which to address access to care disparities, the fact that significant disparities still exist in 2022 and 2023 points to the need for much greater efforts.

Supporters of These Recommendations
Following is a list of employer coalitions and mental health/substance use organizations and philanthropies that support the recommendations in the Report.

National Employer Coalitions
American Health Policy Institute
HR Policy Association
National Alliance of Healthcare Purchaser Coalitions

Regional Employer Coalitions
Dallas-Fort Worth Business Group on Health
Florida Alliance for Healthcare Value
HealthCareTN
Houston Business Coalition on Health
Kansas Business Group on Health
MidAtlantic Business Group on Health
Northeast Business Group on Health
Purchaser Business Group on Health
Texas Business Group on Health

Mental Health/Substance Use Organizations and Philanthropies
American Foundation for Suicide Prevention
American Foundation for Suicide Prevention —GA
Association for Behavioral and Cognitive Therapies
BrainFutures
Eating Disorders Coalition for Research, Policy, & Action
Faces & Voices of Recovery
Georgia Mental Health Policy Partnership
The Goodness Web
The Jed Foundation
The Kennedy Forum
Legal Action Center
Mental Health America
Mental Health Association of Maryland
NAMI, National Alliance on Mental Illness
NAMI Minnesota
National Association for Behavioral Healthcare
National Association of Addiction Treatment Providers
National Council for Mental Wellbeing
Northwestern University, Center for Behavioral Intervention Technologies
One Mind
One Mind PsyberGuide
REDC Consortium
Shatterproof
Steinberg Institute
Sylvan C. Herman Foundation
Treatment Advocacy Center
Young People in Recovery