axene health partners
HEALTH ACTUARIES & CONSULTANTS

Required Coverage and Reimbursement of Annual Behavioral Health Wellness Visits

Maryland Health Care Commission

November 7 2023

Presented by:
Gregory G. Fann, FSA, FCA, MAAA
Consulting Actuary

Erik D. Axene, MD, FACEP, M. Ed
Clinical Consultant

Joan C. Barrett, FSA, MAAA
Consulting Actuary

Ryan Bilton, FSA, CERA, MAAA
Consulting Actuary

Tony Pistilli, FSA, CERA, MAAA, CPC
Consulting Actuary

Table of Contents

Required Coverage and Reimbursement of Annual Behavioral Health Wellness Visits.....

Table of Contents i

Section 1: Executive Summary 3

Introduction 3

Background 3

Key Findings 3

About This Report 3

Section 2. Financial Analysis 4

No Change in Legislation 4

Legislative Impact 5

Section 3. Current Behavioral Health Landscape 6

The Behavioral Health Crisis 6

Barriers to Better Care 6

Emotional Barriers 6

Financial Barriers 6

Provider Shortages 7

Integrated Behavioral Health 7

Federal and State Response 7

The HHS Road Map to Behavioral Health Integration 7

Federal Legislation 7

State Legislation 8

Maryland's Response 8

Section 4. About Behavioral Health Wellness Visits 9

What is a wellness visit? 9

The Importance of Behavioral Health Wellness Visits 9

Clinical Guidelines 9

Section 5. Administrative Issues 10

Section 6. Actuarial Considerations 12

Appendix A. Survey Language 13

Appendix B. Survey Results Summary 14

Appendix C. Payer A Questions 15

Appendix D. Payer B Questions 17

Appendix E. Payer C Questions 20
Appendix F. Payer D Questions 22
Appendix G. Payer E Questions 24

Section 1: Executive Summary

Introduction

Senate Bill 108 was introduced in the Maryland legislature during the 2023 session. The bill did not pass. The Maryland Health Care Commission (MHCC) has retained Axene Health Partners, LLC (AHP) to deliver health care related actuarial services to assist the Commission in completing its legislative requirement under the Insurance Article §15–1501 regarding S.B. 108, including the appropriate fiscal, medical, and social analyses. Since S.B. 108 did not pass, AHP has completed its work assuming that similar legislation is introduced and passed in the current legislative session.

Background

The United States has been experiencing a behavioral health crisis for some time, as demonstrated by the opioid epidemic and an increase in the number of suicides. One solution to address this crisis is transitioning to an approach known as integrated behavioral health. Integrated behavioral health is a "whole person" approach to care and often involves a team of providers including primary care physicians (PCPs), behavioral health specialists, and navigators to help patients find the necessary resources. A potential component of integrated behavioral health is a mandate that insurance carriers cover behavioral wellness visits the same as any other wellness visit; effectively, this means enrollees are not subject to cost sharing.

Key Findings

The ongoing behavioral health crisis in the United States was exacerbated by the COVID-19 pandemic. To lessen the impact, there have been many calls to integrate behavioral health with primary care. One element of this strategy is mandating coverage of behavioral health wellness visits. Ideally, such a mandate would have little to no financial impact on the total cost of care and may in fact save money if there is sufficient reduction in the overall costs of high-cost individuals.

There may be some administrative concerns worthy of consideration, such as how to identify a behavioral wellness visit.

About This Report

This paper includes the following sections with additional information:

- A financial review of the projected costs and potential savings if a related bill is passed
- Background on the behavioral health crisis
- Background on what a behavioral health wellness visit would look like and potential benefits of coverage
- An analysis of potential administrative issues a carrier might encounter if coverage is mandated

Section 2. Financial Analysis

AHP has developed a financial analysis which compares the estimated total impact of the proposed legislation. The model compares total costs for a hypothetical population of 1,000 members assuming in the original legislation. Our analysis shows that there is minimal additional cost attributable to the change is cost sharing and there is potential savings in total costs attributable to reduced costs associated with members with serious mental health issues.

No Change in Legislation

Table 1 summarizes the expected cost increases if the legislation is not passed.

Table 1. Projected Costs Assuming Legislation is Not Passed

			Baseline	Projected Costs				
			2023	2024	2025	2026	2027	2028
a.	Distribution of Members	Other Mental Illness	173	175	176	178	180	182
b.		Serious Mental Illness	55	56	56	57	57	58
c.		No Mental Illness	772	770	767	765	763	760
d.		Total	1,000	$ 1,000	$ 1,000	$ 1,000	$ 1,000	$ 1,000
e.	Cost Per BH Wellness Visit	Allowed Costs	$ 125	$ 131	$ 138	$ 145	$ 152	$ 160
f.		Cost Share	$ 19	$ 20	$ 21	$ 22	$ 23	$ 24
g.		Net Paid	$ 106	$ 112	$ 117	$ 123	$ 129	$ 136
h.	Patients Receiving Care	% Other Mental Illness	47.2%	47.2%	47.2%	47.2%	47.2%	47.2%
i.		% Serious Mental Illness	65.4%	65.4%	65.4%	65.4%	65.4%	65.4%
		Patients Receiving Wellness Visits	118	119	120	121	122	124
j.	Total Costs BH Wellness Visits	Costs Per Visit	$ 106	$ 112	$ 117	$ 123	$ 129	$ 136
k.		Total Costs	$ 12,498	$ 13,254	$ 14,056	$ 14,906	$ 15,808	$ 16,764
l.	Annual Costs Per Patient	Other Mental Illness	$ 7,000	$ 7,490	$ 8,014	$ 8,575	$ 9,176	$ 9,818
m.	(Excluding BH Wellness Visits)	Serious Mental Illness	$ 10,000	$ 10,700	$ 11,449	$ 12,250	$ 13,108	$ 14,026
n.		No Mental Illness	$ 6,000	$ 6,420	$ 6,869	$ 7,350	$ 7,865	$ 8,415
o.		Total	$ 6,393,000	$ 6,844,715	$ 7,328,390	$ 7,846,288	$ 8,400,836	$ 8,994,630
p.	Total Costs	Including BH Wellness Visits	$ 6,405,498	$ 6,857,969	$ 7,342,445	$ 7,861,194	$ 8,416,644	$ 9,011,394
q.	BH as a Percent of Total Costs	BH Wellness Visits	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%

A few comments about this table:

- Information about the distribution of 2023 members (rows a. – d. and rows h.-i.) is based on information from the National Institute of Mental Health[i], adjusted for trends
- Information about the cost distribution (rows j. – k. and rows l. – o.) is based on AHP proprietary data
- Cost per service trends are assumed to be 5% across the board and total cost PMPY trends are assumed to be 7%

Legislative Impact

The estimated impact of the legislation is shown in Table 2.

Table 2. Legislative Impact

			Baseline	Projected Costs				
			2023	2024	2025	2026	2027	2028
a.	Distribution of Members	Other Mental Illness	173	175	176	178	180	182
b.		Serious Mental Illness	55	56	56	57	57	58
c.		No Mental Illness	772	770	767	765	763	760
d.		Total	1,000	$ 1,000	$ 1,000	$ 1,000	$ 1,000	$ 1,000
e.	Cost Per BH Wellness Visit	Allowed Charges	$ 125	$ 131	$ 138	$ 145	$ 152	$ 136
f.		Cost Share	$ 19	$ -	$ -	$ -	$ -	$ -
g.		Net Paid	$ 106	$ 131	$ 138	$ 145	$ 152	$ 136
h.	Patients Receiving Care	% Other Mental Illness	47.2%	48.1%	49.1%	50.1%	51.1%	52.1%
i.		% Serious Mental Illness	65.4%	66.7%	68.0%	69.4%	70.8%	72.2%
		Patients Receiving Wellness Visits	118	121	125	129	132	136
j.	Total Costs BH Wellness Visits	Costs Per Visit	$ 106	$ 131	$ 138	$ 145	$ 152	$ 136
k.		Total Costs	$ 12,498	$ 15,905	$ 17,204	$ 18,610	$ 20,131	$ 18,509
l.	Net Impact of Legislation	Other Mental Illness	0%	3%	-1%	-1%	-1%	-1%
m.	on TCOC	Serious Mental Illness	0%	3%	-1%	-1%	-1%	-1%
n.		No Mental Illness	0%	0%	0%	0%	0%	0%
o.	Annual Costs Per Patient	Other Mental Illness	$ 7,000	$ 7,715	$ 7,934	$ 8,490	$ 9,084	$ 9,720
p.	(Excluding BH Wellness Visits)	Serious Mental Illness	$ 10,000	$ 11,021	$ 11,335	$ 12,128	$ 12,977	$ 13,885
q.		No Mental Illness	$ 6,000	$ 6,420	$ 6,869	$ 7,350	$ 7,865	$ 8,415
r.		Total	$ 6,393,000	$ 6,901,808	$ 7,307,823	$ 7,824,061	$ 8,376,815	$ 8,968,671
s.	Total Costs	BH Wellness Visits	$ 12,498	$ 15,905	$ 17,204	$ 18,610	$ 20,131	$ 18,509
t.		Other Costs	$ 6,393,000	$ 6,901,808	$ 7,307,823	$ 7,824,061	$ 8,376,815	$ 8,968,671
v.		Total Costs	$ 6,405,498	$ 6,917,713	$ 7,325,027	$ 7,842,671	$ 8,396,946	$ 8,987,180
w.	Change Due to Legislation	Total Costs	$ 0	$ 59,744	$ (17,418)	$ (18,523)	$ (19,698)	$ (24,214)
x.		% of Total Costs	0.0%	0.9%	-0.2%	-0.2%	-0.2%	-0.3%

The key assumptions underlying this table are:

- The percentage of the population with a mental illness will not change because of the legislation (rows a. – d.).
- There will be no cost share after the legislation is passed.
- The percentage of people receiving care will increase by 2% per year.
- There will be a one-time increase in costs due to the technology costs the first year after the legislation is passed, but there will be a decrease in costs after that.

Section 3. Current Behavioral Health Landscape

The purpose of this section is to provide an overview of the current behavioral health landscape and provide context for the social and financial evaluation sections of this report.

The Behavioral Health Crisis

Mental health disorders are one of the leading health-related problems on the planet. It is becoming a larger public health concern in the US as rates of anxiety, depression and suicide continue to rise. In 2001 suicide rates had leveled off at 10.7 deaths per 100,000 and this rate has been steadily increasing with the largest ever recorded increase between 2020 and 2021 when the suicide rate jumped up from 13.5 to 14.2 deaths per 100,000.[1] There are a myriad of factors that seem to be impacting the mental health of Americans.

In the "Interpersonal Theory of Suicide", it was surmised that the greatest predictor of suicidal ideation and suicide attempts were social isolation. This concern led to US Surgeon General (Dr Vivek H. Murthy) releasing his advisory brief "Our Epidemic of Loneliness and Isolation"[2] highlighting the current state of mental health in the US. Dr. Murthy appeals to our country when he counsels us to "build a movement to mend the social fabric of our nation". Dr Murthy goes on to say, "Given the totality of the evidence, social connection may be one of the strongest protective factors against self-harm and suicide among people with and without serious underlying mental health challenges[id]".

The COVID-19 pandemic has had a disturbing effect on the health of millions of Americans but the most dramatic health detriments have been the related mental health effects.[4] A study in the Lancet quantified the impact of the pandemic on behavioral health. Estimates indicate "that cases of depression rose by 53 million globally as a consequence of the pandemic, 28% above pre-pandemic levels; cases of anxiety increased by 76 million, a 26% increase[id]".

In addition to the awful impact COVID-19 had on mental health in the US, it has produced a perfect storm leaving individuals exposed to mental health crises with little support.[5] Factors such as social isolation, lockdowns, school closures, loss of livelihood, and decreases in economic activity all have substantially affected the mental health of the US population. A recent national survey showed that, by April 2021, one in four individuals reported feeling less close to family members compared to the beginning of the pandemic.[3]

Barriers to Better Care

The first step in addressing the behavioral health crisis is to identify the emotional, structural, and financial barriers to better health.

Emotional Barriers

A person with a behavioral health problem faces many barriers in their journey to better health, starting with emotional barriers. In some cases, the person may not recognize that they have a problem, which is the first step in the process. Others may recognize that they have a problem but are reluctant to receive care because of the stigma associated with receiving care. This is especially true of children and teenagers fearful of parental disapproval.

Financial Barriers

In 2020, 30% of adults aged 18 or older who had a behavioral health condition reported not receiving care because their insurance did not cover the services or did not pay enough for the service.[ii] Although the

Mental Health and Addiction Equity Act of 2008 mandated equal coverage for mental health and other medical conditions, gaps still exist and are growing.

Such gaps may be partially due to insurance practices like arbitrary medical necessity rules, network inadequacy, and required step therapy. For example, individuals seeking care through an in-network primary care physician may have coverage denied because the plan has a mental health carve-out. Similarly, many behavioral health specialists, especially psychiatrists, refuse to join a network because the reimbursement is more favorable on an out-of-network basis. From a consumer perspective, that means the service may not be covered at all under in-network only plans or it may be covered at a higher cost-share on a plan that does cover the service on an out-of-network basis.

Provider Shortages

Nationally, 165 million Americans, roughly half the country, live in designated health professional shortage areas (HPSA). The Health Resources and Services Agency estimates that 8,326 more providers are needed, including approximately 4,500 facilities.[iii]

Integrated Behavioral Health

In recent years, there have been several calls to move toward integrating behavioral health services with primary services and navigator resources to achieve a "whole person" approach to care. The emphasis on integrated behavioral health is driven in part by the fact that 70% of patients with a behavioral health disorder have a medical comorbidity and 30% of adults with a medical condition also have a behavioral health comorbidity. The American Hospital Association has listed[iv] several potential benefits for integrated care, including improved patient outcomes, reduced total cost of care. increased access to behavioral health services, and enhanced patient satisfaction.

Federal and State Response

State and federal agencies are responding to the behavioral health crisis.

The HHS Road Map to Behavioral Health Integration

At President Biden's direction, the Department of Health and Human Services (HHS) has articulated a strategy to address behavioral health integration. The key components of this strategy include developing a diverse workforce to practice in integrated settings, leveraging health financing arrangements to promote parity, and investing in health promotion efforts.

Federal Legislation

Recent mental health legislation at the federal level includes:

- **Mental Health Parity and Addiction Equity Act (MHPAEA)**: This law requires health insurance plans that cover mental health and substance use disorder services to provide coverage that is comparable to coverage for medical and surgical services. It prohibits discrimination in the coverage of behavioral health services.

- **21st Century Cures Act**: Enacted in 2016, this legislation includes provisions related to mental health and substance use disorders. It provides funding for various behavioral health programs, supports the expansion of mental health services, and promotes research in the field.

- **Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act**: This comprehensive law, signed in 2018, addresses the opioid

crisis and includes provisions to expand access to addiction treatment, prevention, and recovery services.

- **Comprehensive Addiction and Recovery Act (CARA)**: This law, signed in 2016, focuses on addressing opioid addiction and overdose. It includes provisions for increasing access to medication-assisted treatment (MAT) and expanding resources for addiction prevention and recovery.

- **Project AWARE (Advancing Wellness and Resilience in Education)**: This initiative includes a federal grant program that supports mental health awareness training for educators, school staff, and communities to help identify and respond to behavioral health issues in children and adolescents.

- **National Suicide Hotline Designation Act**: This legislation designated "988" as the new national three-digit number for the National Suicide Prevention Lifeline, making it easier for people in crisis to access help.

State Legislation

Several states have enacted behavioral health related legislation recently. For example, Delaware passed legislation requiring behavioral health wellness visits.[v]

Maryland's Response

Maryland's 2021 – 2022 Behavioral Health Crisis System Workgroup made several recommendations relating to best practices, a mobile response system for children, and the implementation of the 988 suicide prevention hotline. Maryland also has a system of hotlines and walk-in urgent care centers to assist Marylanders.[vi]

Section 4. About Behavioral Health Wellness Visits

What is a wellness visit?

A behavioral health wellness visit typically includes[vii]:

- An Assessment. A behavioral health assessment is similar to a medical assessment and generally includes gathering information on risk factors, comorbid conditions, and family history. The assessment is generally done in advance on paper or online. Ideally, the assessment relies on a valid, reliable survey instrument.
- Diagnosis and Treatment. Based on the assessment, a provider may diagnose the patient, provide some type of treatment, and/or refer the patient to another provider.
- Prevention and Health Promotion. The provider may share preventive information with the patient specific to their needs.
- Resources. The provider may also share information about resources available to the patient locally or through their insurance carrier.

The wellness visit may be conducted in person or online. In 2022 approximately 30% of all behavioral health services were conducted online.[viii] In part, this is because there is little or no physical examination during a behavioral health visit and simply because it is more convenient.

The Importance of Behavioral Health Wellness Visits

It is common in our society to prioritize our physical health over our mental health. The chasm between these two equally important components of our overall health is beginning to narrow. We are still overcoming some of the negative undertones associated with seeing a psychiatrist for mental health disorders which is one of many reasons we prioritize physical health diseases. Mount Sinai Medical Center, in its article Mental Health Check-up and its Importance[6], says that "Early identification and treatment is especially helpful because later stages often trigger some kind of personal crisis, which then makes treatment much more involved [and expensive].[id]" Dr Enamorado (psychiatrist with Mount Sinai Medical Center) goes on to say that "having a mental health checkup is just as important, and should be conducted with the same regularity, as a physical checkup.[id]"

Clinical Guidelines

There is a myriad of clinical guidelines for behavioral health disorders, including those for autism, substance abuse, and eating disorders.[ix] The United States Preventive Services Task Force, however, only gives A or B recommendations to screenings for anxiety, depression, and substance abuse. An A or B rating means that the Task Force highly recommends the screening and there is a moderate to high net benefit to the patient. In Maryland, the definition of a preventive service includes most USPSTF A and B recommended services.

Section 5. Administrative Issues

A survey of five health insurance payers was conducted to assess industry concerns with a behavioral health wellness visit mandate without cost-sharing.

In the current marketplace, behavioral health wellness visits are generally covered and subject to cost-sharing. Sometimes a non-behavioral health primary care office visit includes a behavioral health screening which may lead to a referral to a behavioral health specialist. If a behavioral health wellness visit is recorded as preventive care, it may be covered without cost-sharing. The use of telehealth services for behavioral health is often covered the same as in-person visits. Additionally, some payers provide an online behavioral health self-assessment that is free for members.

For purposes of determining cost-sharing provisions, some payers regard behavioral health specialists as primary care providers other payers regard behavioral health providers as specialists. In general, some payers have a 'Preventive Coverage Policy' which encompasses behavioral health wellness visits. Some payers specifically delineate medical policy related to behavioral health wellness visits.

If behavioral health wellness visits without cost-sharing are mandated, a successful implementation would include clarification on provider billing code requirements/expectations and sufficient implementation time. Payer contracting and system updates to accommodate waiving cost-sharing require significant time and resources.

It is also important to consider that policy changes could create workforce capacity issues. Those in greatest need should be able to access care. As an alternative to a behavioral health wellness visit, some payers advocate the use of integrated care and trained primary care professionals who can perform a behavioral health wellness check during an annual physical wellness exam and refer patients as appropriate to a behavioral health specialist. An idea behind this advocacy is that it will ensure there are adequate resources for those needing more complex care instead of diverting the time of specialized behavioral health providers. Furthermore, there is concern that mandating a specific behavioral health wellness visit may exacerbate existing silos between primary care and behavioral health and behavioral health should be addressed as part of the standard wellness exam to promote overall health.

With a behavioral health wellness visit mandate, clarity is needed on the definition of a behavioral health wellness visit, as well as specifications on the scope of which providers can provide the annual behavioral health wellness exam as clear definition of codes/modifiers used to identify and distinguish these services from other office visits. Additionally, the ability to track the use of annual behavioral health wellness is viewed as important.

From a financial perspective, one payer believes incorporating behavioral health wellness checks into the standard annual physical wellness visit is more cost-effective. Some payers believe a single annual behavioral health visit limit and the use of telehealth align with medical preventive care to control and manage costs. Other payers generally believe this mandate will increase system cost and potentially divert attention of behavioral health professionals to patients with less acuity.

To minimize the potential for fraud, waste and abuse with such a mandate, there should be checks in place to assure that only the appropriate number of wellness visits are conducted and/or cost-sharing is only waived for the appropriate number of visits. The potential for fraud, waste and abuse monitoring will

also be dependent upon billing codes in use. One payer believes patients prone to misusing this type of service may exaggerate their symptoms and receive priority for appointments in an already constrained appointment opportunity.

Section 6. Actuarial Considerations

This report has been prepared by Gregory G. Fann, FSA, FCA, MAAA, who is also the primary contact. The report has been peer-reviewed by:

- Erik D. Axene, MD, FACEP, M.Ed.
- Joan C. Barrett, FSA, MAAA
- Ryan Bilton, FSA, CERA, MAAA
- Tony Pistilli, FSA, CERA, MAAA, CPC

Except for our clinical expert, Dr. Axene, all members of the team members of the American Academy of Actuaries (MAAA) in good standing and are qualified to perform this work. This report was prepared in accordance with the following Standards of Practice as promulgated by the Actuarial Standards Board of the American Academy of Actuaries:

- Actuarial Standards of Practice No. 1, "Introductory Standard of Practice"
- Actuarial Standards of Practice No. 5, "Incurred Health and Disability Claims"
- Actuarial Standards of Practice No. 23, "Data Quality"
- Actuarial Standards of Practice No. 25, "Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages"
- Actuarial Standards of Practice No. 41, "Actuarial Communication"
- Actuarial Standards of Practice No. 56, "Modeling"

Although AHP has performed due diligence in researching the legal implications of this analysis, this report does not constitute a legal opinion and the reader should consult their own legal counsel about specific legal issues.

Appendix A. Survey Language

MARYLAND HEALTH CARE COMMISSION
Procurement ID Number: MHCC 24-006
Carrier Name:
Contact Person Name:
Contact Person Email:

The purpose of this survey is to determine whether carriers provide coverage and reimburse an annual behavioral health wellness visit on the same basis and at the same rate as an annual wellness visit for somatic health.

1. Do you currently cover in-person behavioral health wellness visits? If so, are they treated as wellness visits (no cost-sharing) or a typical office visit with cost-sharing?

2. Do you currently cover virtual (telehealth) behavioral health wellness visits? If so, are they treated the same as in-person visits?

3. Do you currently offer an online behavioral health self-assessment screening tool that does not involve a provider? If so, are there any financial incentives or cost sharing?

4. Are behavioral health providers treated as specialists or primary care providers for cost sharing purposes?

5. Do you have a specific medical policy relating to behavioral health wellness visits? If so, please describe the key components of the policy.

6. If behavioral health wellness visits are mandated, what are the issues needing to be addressed for successful implementation?

7. If behavioral health wellness visits are mandated, what are the major challenges, if any, to manage costs and utilization while providing appropriate access?

8. If behavioral health wellness visits are mandated, what are the new major issues, if any, to minimize the potential for fraud, waste and abuse?

Appendix B. Survey Results Summary

MARYLAND HEALTH CARE COMMISSION
Procurement ID Number: MHCC 24-006
Carrier Name:
Contact Person Name:
Contact Person Email:

Appendix C. Payer A Questions

1. Do you currently cover in-person behavioral health wellness visits? If so, are they treated as wellness visits (no cost-sharing) or a typical office visit with cost-sharing?

We standardly covers in-person behavioral health assessment and therapy services (i.e. 90791-90792, 90832-90837) and services are subject to cost-sharing, per terms of the plan.

2. Do you currently cover virtual (telehealth) behavioral health wellness visits? If so, are they treated the same as in-person visits?

We standardly covers virtual (telehealth) behavioral health assessment and therapy services (i.e. 90791-90792, 90832-90837) and services are subject to cost-sharing, per terms of the plan.

3. Do you currently offer an online behavioral health self-assessment screening tool that does not involve a provider? If so, are there any financial incentives or cost sharing?

No.

4. Are behavioral health providers treated as specialists or primary care providers for cost sharing purposes?

Specialist.

5. Do you have a specific medical policy relating to behavioral health wellness visits? If so, please describe the key components of the policy.

N/A

6. If behavioral health wellness visits are mandated, what are the issues needing to be addressed for successful implementation?

Clarification on provider billing code requirements/expectations. Sufficient implementation time, as contracting and system updates to accommodate cost-share waiving require significant time and resources.

7. If behavioral health wellness visits are mandated, what are the major challenges, if any, to manage costs and utilization while providing appropriate access?

Ensure checks are in place that only the appropriate number of wellness visits are conducted and/or cost-share is only waived for the appropriate number of visits.

8. If behavioral health wellness visits are mandated, what are the new major issues, if any, to minimize the potential for fraud, waste and abuse?

Ensure checks are in place that only the appropriate number of wellness visits are conducted and/or cost-share is only waived for the appropriate number of visits. The potential for FWA monitoring will also be dependent upon billing codes in use – if recommended codes can be used for other services, FWA monitoring will be more complicated.

Appendix D. Payer B Questions

1. Do you currently cover in-person behavioral health wellness visits? If so, are they treated as wellness visits (no cost-sharing) or a typical office visit with cost-sharing?

We encourage primary care providers and pediatricians to do initial screenings for behavioral health and then refer, as needed, to a behavioral health specialist. Behavioral Health visits are covered, including Diagnostics, with cost-share.

2. Do you currently cover virtual (telehealth) behavioral health wellness visits? If so, are they treated the same as in-person visits?

Yes, see above.

3. Do you currently offer an online behavioral health self-assessment screening tool that does not involve a provider? If so, are there any financial incentives or cost sharing?

Yes; it is free for members.

4. Are behavioral health providers treated as specialists or primary care providers for cost sharing purposes?

For Maryland insured products in 2024, our cost sharing aligns with the primary care providers.

5. Do you have a specific medical policy relating to behavioral health wellness visits? If so, please describe the key components of the policy.

See #1. BH services, including diagnostics are covered for member initiating contact with providers based on their perceived need for care. If diagnostic criteria has not been met for a mental disorder, we still reimburse the provider for services rendered.

6. If behavioral health wellness visits are mandated, what are the issues needing to be addressed for successful implementation?

There should be consideration for the existing behavioral health (MH/SUD) workforce capacity issues to ensure those in greatest need are able to access care. We encourage the use of integrated care and believe primary care professionals (M.D., D.O., PA, NP etc.) who are trained in behavioral health to perform a behavioral health wellness check during an annual wellness exam (i.e., physical) and then refer, if needed, to a behavioral health specialist. This will ensure there are adequate resources for those needing more complex care instead of diverting the time of specialized behavioral health providers. Furthermore, mandating a behavioral health wellness visit exacerbates existing silos between primary care and behavioral health. Behavioral health should be addressed as part of the standard wellness exam to promote overall health.

7. If behavioral health wellness visits are mandated, what are the major challenges, if any, to manage costs and utilization while providing appropriate access?

See #6. If behavioral health wellness visits are mandated, costs and utilization will increase across the board. Incorporating behavioral health wellness checks into the standard annual wellness will help to alleviate this issue and ensure timely access to care. Additionally, mandating visits will exacerbate existing provider shortages which could have the unintended consequences of increased wait times and individuals going out of network to receive care which will increase patient costs.

8. If behavioral health wellness visits are mandated, what are the new major issues, if any, to minimize the potential for fraud, waste and abuse?

Mandating behavioral health wellness visits could potentially incentivize providers to increase their visit volume to perform this service. This will have negative downstream implications for health outcomes as providers will have reduced time to provide care and counsel to individuals with more complex behavioral health needs. This could lead to individuals receiving delayed care or forgoing care entirely which will likely result in increased costs to the health care system, particularly for individuals with comorbidities.

Appendix E. Payer C Questions

1. Do you currently cover in-person behavioral health wellness visits? If so, are they treated as wellness visits (no cost-sharing) or a typical office visit with cost-sharing?

Yes. Covered as a typical office visit with cost-sharing.

2. Do you currently cover virtual (telehealth) behavioral health wellness visits? If so, are they treated the same as in-person visits?

Yes. Telehealth visits are currently covered with no cost share.

3. Do you currently offer an online behavioral health self-assessment screening tool that does not involve a provider? If so, are there any financial incentives or cost sharing?

No. All self-assessments are used by providers to assess clinical acuity and develop treatment plans, and monitor clinical progress.

4. Are behavioral health providers treated as specialists or primary care providers for cost sharing purposes?

Primary care providers.

5. Do you have a specific medical policy relating to behavioral health wellness visits? If so, please describe the key components of the policy.

No

6. If behavioral health wellness visits are mandated, what are the issues needing to be addressed for successful implementation?

Staffing, coding, billing. This type of service would be best accomplished by Employee Assistance Programs and/or by Behavioral Medicine Specialists.

7. If behavioral health wellness visits are mandated, what are the major challenges, if any, to manage costs and utilization while providing appropriate access?

Wellness visits are not performed by most network providers/practices so this mandate would create a significant increase in competition for appointments. These visits would be a strain on access for patients who have proactively reached out of mental health therapy. Access for urgent care, routine follow-up, and new evaluations have lengthened the time it takes to be able to adequately meet current demands. Adding this mandate will require developing a new appointment type, appropriate billing and coding system integrations, and increased staffing.

8. If behavioral health wellness visits are mandated, what are the new major issues, if any, to minimize the potential for fraud, waste and abuse?

Adherence to measurement outcomes (PHQ-9/GAD-7/CSSRS) will be a challenge. Patients prone to misusing this type of service will falsely elevate or exaggerate their symptoms and receive priority for appointments in an already constrained appointment opportunity.

Appendix F. Payer D Questions

1. Do you currently cover in-person behavioral health wellness visits? If so, are they treated as wellness visits (no cost-sharing) or a typical office visit with cost-sharing?

Yes. Typically, these visits are billed by the provider using a standard office visit code and the applicable office visit cost share would apply.

2. Do you currently cover virtual (telehealth) behavioral health wellness visits? If so, are they treated the same as in-person visits?

Yes, and Yes.

3. Do you currently offer an online behavioral health self-assessment screening tool that does not involve a provider? If so, are there any financial incentives or cost sharing?

Yes. No cost sharing is applied.

4. Are behavioral health providers treated as specialists or primary care providers for cost sharing purposes?

It depends, cost sharing is determined consistent with federal MHPAEA requirements and can result in behavioral health services and providers being aligned to primary care or specialist depending on the terms of the plan.

5. Do you have a specific medical policy relating to behavioral health wellness visits? If so, please describe the key components of the policy.

We are unaware of any specific medical/clinical policy related to behavioral health wellness visits but here is a link to our general medical policy relating to behavioral health.

6. If behavioral health wellness visits are mandated, what are the issues needing to be addressed for successful implementation?

Key issues we have encountered in states which have implemented annual behavioral health wellness exam/visits mandates include: (1) specifications on the scope of which providers can provide the annual behavioral health wellness exam; (2) clear definition of codes/modifiers used to identify and distinguish these services from other office visits and can be used by all types of providers who are in scope to provide these services; and (3) ability to track the use of annual behavioral health wellness.

7. If behavioral health wellness visits are mandated, what are the major challenges, if any, to manage costs and utilization while providing appropriate access?

Key issues we have encountered in states which have implemented annual behavioral health wellness exam/visits mandates include: (1) specifications on the scope of which providers can provide the annual behavioral health wellness exam; (2) clear definition of codes/modifiers used to identify and distinguish these services from other office visits and can be sued by all types of providers who are ins cope to provide these services; and (3) ability to track the use of annual behavioral health wellness.

8. If behavioral health wellness visits are mandated, what are the new major issues, if any, to minimize the potential for fraud, waste and abuse?

No new major issues have been identified.

Appendix G. Payer E Questions

1. Do you currently cover in-person behavioral health wellness visits? If so, are they treated as wellness visits (no cost-sharing) or a typical office visit with cost-sharing?

Yes, we cover in-person behavioral wellness visits. If visit is billed as preventive, it will pay at no cost share. If billed as diagnostic, it would pay according to the member benefit.

2. Do you currently cover virtual (telehealth) behavioral health wellness visits? If so, are they treated the same as in-person visits?

Yes, we cover virtual (telehealth) behavioral health wellness visits same as in-person.

3. Do you currently offer an online behavioral health self-assessment screening tool that does not involve a provider? If so, are there any financial incentives or cost sharing?

We currently offer depression and anxiety screenings on aetna.com regardless of membership. We have a number of buy-up programs where incentives for completing health and wellness assessments is dependent upon the incentive structure of the plan's program. Incentives can yield points or dollars, and completion can result in redemption of gift cards, HSA contributions, or premium deductions.

4. Are behavioral health providers treated as specialists or primary care providers for cost sharing purposes?

Behavioral health providers are treated as specialists for cost sharing purposes.

5. Do you have a specific medical policy relating to behavioral health wellness visits? If so, please describe the key components of the policy.

We have a Preventive Coverage Policy that encompasses behavioral health wellness visits. For plans that are covered under ACA we provide wellness visits as required by the following agencies according to preventive care guidelines: • Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) • United States Preventive Services Task Force (USPSTF) • Health Resources and Services Administration • American Academy of Pediatrics/Bright Futures/Health Resources and Services -Administration guidelines for children and adolescents.

6. If behavioral health wellness visits are mandated, what are the issues needing to be addressed for successful implementation?

Any issues would be dependent on how a state defines wellness visits and outlines requirements. Detailed diagnostic and procedure codes are recommended for clarity.

7. If behavioral health wellness visits are mandated, what are the major challenges, if any, to manage costs and utilization while providing appropriate access?

We recommend a single annual visit limit to align with medical preventive care to control and manage costs. We encourage telehealth to support member access to care.

8. If behavioral health wellness visits are mandated, what are the new major issues, if any, to minimize the potential for fraud, waste and abuse?

Should new major issues arise if BH wellness visits are mandated, we have a dedicated department to monitor and address as needed.

Endnotes

[i] NIMH » Mental Illness (nih.gov)
[ii] Exploring Barriers to Mental Health Care in the U.S. | Research and Action Institute (aamcresearchinstitute.org)
[iii] Shortage Areas (hrsa.gov)
[iv] Integrating Physical and Behavioral Health: The Time is Now | AHA
[v] Health Costs, Coverage and Delivery State Legislation (ncsl.org)
[vi] Behavioral Health Walk-In & Urgent Care Centers. Resource Guide 2023.9.6. (maryland.gov)
[vii] O'Donohue, William, Zimmerman, Martha, Handbook of Evidence-Based Prevention of Behavioral Disorders in Integrated Care, A Stepped Approach ISBN978-3-030-83468-5, Springer, 2021
[viii] Choosing Or Losing In Behavioral Health: A Study Of Patients' Experiences Selecting Telehealth Versus In-Person Care | Health Affairs
[ix] Behavioral Health Clinical Practice Guidelines 2020-2021 | Blue Cross and Blue Shield of New Mexico (bcbsnm.com)