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December 20, 2022

**MICHAEL DRAKE, PRESIDENT
UNIVERSITY OF CALIFORNIA**

Re: Report on Improving Access in Behavioral Health

Dear President Drake:

At its December 14 meeting, the Academic Council endorsed the attached report from the University Committee on Faculty Welfare Health Care Task Force (UCFW-HCTF) Behavioral Health Working Group (BeHWoG). The report analyzes problems associated with access to behavioral health care within UC provider networks, as well as options for improved access and delivery.

The report found that significant barriers to behavioral healthcare access are affecting UC employees at every campus and location. The problems facing employees include: difficulty finding behavioral health providers who meet their needs; and too many “ghost providers” who are listed as available in insurance networks but who do not actually take UC insurance or see UC patients.

The report makes several recommendations for improving access to quality behavioral healthcare. These include: better leveraging UC Health resources in ways that expand UC training programs for behavioral health clinicians and that increase the participation of UC psychiatrists in UC employee health plans; implementing additional prevention resources for employees; working with insurance plans to address the ghost provider issue, low reimbursement rates, and new cost-sharing options; increasing access to telehealth; and better monitoring health plans to ensure accountability.

The current national mental health crisis makes it more important than ever that UC address these issues, not only to better serve our own employees but also to further extend our public mission to provide healthcare leadership in service to the state of California and its people.

We look forward to working with you on this issue. Please do not hesitate to contact me if you have additional questions.

Sincerely,



Susan Cochran, Chair
Academic Council

Cc: Executive Vice President Byington
Vice President Lloyd
Academic Council
UCFW Chair Dalton
UCFW-HCTF Chair Ong
Provost Brown
Chief of Staff Kao
Chief Policy Advisor McAuliffe
Campus Senate Directors
Executive Director Lin

Encl.



UNIVERSITY COMMITTEE ON FACULTY WELFARE (UCFW)
Terry Dalton, Chair
tdalton@uci.edu

Assembly of the Academic Senate
1111 Franklin Street, 12th Floor
Oakland, CA 94607-5200

December 5, 2022

**SUSAN COCHRAN, CHAIR
ACADEMIC COUNCIL**

RE: Behavioral Health Access and Options

Dear Susan,

The University Committee on Faculty Welfare (UCFW) is pleased to share the enclosed report from our Health Care Task Force's (HCTF) Behavioral Health Working Group (BeHWoG) analyzing access and options for improved delivery of behavioral health. BeHWoG worked closely with systemwide Human Resources and UC Care officials for more than a year to investigate the situation and create recommendations. Absent significant new resources, short-term options are limited, but we note that UC Health could increase training in this area, both to future professionals and to those, like faculty, who are called upon to provide ad hoc services. We ask that you endorse the report and share it with relevant UC leaders. UCFW and HCTF are ready to help address this emerging crisis.

Thank you for your attention to this important matter.

Sincerely,

Terry Dalton, UCFW Chair

Encl.

Copy: UCFW
Monica Lin, Executive Director, Academic Senate
James Steintrager, Academic Council Vice Chair

Improving Access in Behavioral Health: Second Report*

Report Submitted to Health Care Task Force

8/29/2022

Behavioral Health Workgroup (BeHWoG)

Joel E Dimsdale, Chair (Psychiatry, UCSD)

Ben Handel (Economics, UCB)

Shelley Halpain (Biological Sciences, UCSD)

Robert May (Philosophy, Davis)

Jeanne Miranda (Psychiatry, UCLA)

Susan Pon-Gee (UC HR, Health and Welfare Benefits)

Laura Tauber (UC Self-Funded Health Plans)

*This report extends and replaces the original report (“Access Problems in Behavioral Health”) submitted July 13, 2021, and authored by Dimsdale, Jackson-Triche, May, Miranda, Pon-Gee, and Tauber.

Table of Contents

- EXECUTIVE SUMMARY 3**
 - Purpose of the Report..... 3
 - Key Findings and Recommendations 3

- SECTION I: INTRODUCTION..... 4**
 - I.1 Review Process 4
 - I.2 Sources 4

- SECTION II: DEFINING THE SCOPE OF ACCESS PROBLEMS 4**
 - II.1 How is access defined? 4
 - II.2 Anecdotal reports 5
 - II.3 Survey data 6
 - II.4 Evaluating network adequacy 12

- III: POTENTIAL SOLUTIONS 21**
 - III.1 UC Health Centers and Departments of Psychiatry.....21
 - III.2 Prevention.....22
 - III.3 Network.....23
 - III.4 Telehealth.....25
 - III.5 Digital Point Solutions.....25
 - III.6 Reimbursement.....26
 - III.7 Carving out.....29
 - III.8 Responding to innovative treatments29
 - III.9 Generalizability to retirees?.....29

- SECTION IV: NEXT STEPS AND RECOMMENDATIONS 30**

Executive Summary

After receiving numerous complaints about problems in accessing behavioral health care, the Academic Senate's Health Care Task Force empaneled a Behavioral Health Workgroup (BeHWoG) to determine the scope of the problem and potential remedies. The group relied on testimony from each campus as well as recently conducted surveys.

Almost half of respondents said it was difficult to find any behavioral health provider to meet their needs, and most had to phone numerous providers before obtaining an appointment. Contrary to expectations, such problems were seen in regions regardless of population density (e.g. San Francisco and Merced). Problems were reported from employees of all educational backgrounds and salary levels. Some employees were forced to go out of network and found the behavioral healthcare unaffordable. Technological solutions have been only partially helpful.

The networks themselves are replete with "ghost providers" who are listed as available but do not see any UC patients. Even within UC Health, many behavioral health providers appear to be ghosts who do not see Blue & Gold or PPO plan patients. There are intriguing inter-campus differences in how often this occurs.

Key recommendations:

- For campuses with academic health centers, increased participation of their departments of psychiatry could help.
- Given the shortage of providers, UC needs to examine prevention resources such as Employee Assistance Programs and Community Behavioral Health Clinicians.
- UC should expand training in relevant clinical programs to address the enormous shortage of behavioral health clinicians.
- Insurance companies need to monitor their networks more closely and address problems. Increased use of single payer agreements or service overlays may help correct network deficiencies if the providers are willing to take them.
- UC should continue emphasizing telehealth because of its potential to augment networks, but it will not solve access problems, given the existing network reimbursements.
- Digital point solutions offer considerable promise as a supplement to existing behavioral health care delivery options.
- Adoption of consistent metrics for quality of care and access should be sought for all health plans.

Section I: Introduction

I.1 Review Process:

The workgroup was constituted by the Health Care Task Force in December 2020 to investigate access and quality of care issues related to behavioral healthcare delivery for staff, faculty, and retirees who utilize insurance programs offered by UC during open enrollment. There have been longstanding complaints of access problems in obtaining such care. The group met 14 times to discuss such issues.

Given that 44% of employees report that they or someone on their plan needed behavioral health services in the past two years, these access problems affect many employees. Furthermore, of those who sought care, one in three were dissatisfied with the overall process of getting behavioral care. In comparison, only 7% were dissatisfied with the medical care they received. The wait times were specifically called out, with 19% of employees having to wait 1-3 months for a behavioral health appointment. Eight percent had to wait >3 months.¹

I.2 Sources:

There are abundant UC data documenting problems with access to behavioral health care. The workgroup focused particularly on two sources. A 2020 survey by Greenwald and Associates Marketing Firm on behalf of UC Health received responses from 4,294 UC active employees across all campuses regarding health and wellbeing. In addition, we relied on the Experience of Care and Health Outcomes (ECHO Survey), which monitors plan satisfaction specific to behavioral health services. Three thousand three hundred UC medical plan members who received behavioral health services from HSP, Kaiser Overlay (Optum), Health Net Blue & Gold, Health Net Seniority Plus, and UC Care during 2019 were randomly selected to participate in a 2020 survey. Additionally, Kaiser conducted its own survey of 4,400 members using a questionnaire that is similar to the ECHO survey. While there are differences in the questions asked in these two instruments, the surveys point to similar conclusions.

In addition to the surveys, the group obtained outside testimony from campus healthcare facilitators, employee assistance programs (EAP), experts in telehealth, outpatient psychiatry directors, and Office of the General Counsel. Furthermore, we arranged for the Health Care Task Force to meet with leaders of Kaiser to discuss behavioral issues in their system.

Section II: Defining the Scope of Access Problems

II.1 How is access defined?

The historical concerns about behavioral health coverage have centered around access. How long does it take to get an appointment for urgent concerns, for non-urgent concerns? What is

¹ UC Employee Plan Subscriber Survey: Wellbeing and care seeking, presented 4/16/21 to HCTF, slides 52 and 53

the access for longer term psychotherapy? What is access like for sub-specialists like child psychiatrists?

Demand for mental health services exceeds supply, and providers are selective in accepting patients. Providers may: 1) opt out of joining plan networks and see private paying patients only; or 2) join networks but select patients whose insurance plans offer the highest reimbursement rates.

Are there enough clinicians available in the various regions of California? If there are regional differences in access, do they reflect absence of providers (e.g. Merced) or a general unwillingness of providers to accept the insurance (e.g. Berkeley)? Are the provider lists as proffered by the insurance companies accurate or are there too many ghost providers (providers who are not seeing UC patients)? Are there certain types of providers who are notably hard to access (e.g. providers from minority backgrounds, child psychiatrists, those treating substance use disorders, those specializing in LGBTQ issues)? These are the sorts of questions the workgroup considered.

II.2 Anecdotal reports:

Kaiser has historically been faulted for its limited access for substance use disorders and ongoing psychotherapy. Kaiser is organized differently across the state, and in the future, it may be useful to explicitly contrast Northern and Southern California Kaiser experience. In general, there was some agreement that access has improved since UC contracted with Optum Behavioral Health in 2008 to provide a Kaiser overlay. We received differing reports about Northern California Kaiser. When interviewing EAP professionals across the campuses, one respondent indicated that Kaiser has improved slightly in terms of seeing psychiatrists, but ongoing psychotherapy continues to be sparse and limited to a small number of sessions. On the other hand, another Northern California representative observed no noticeable improvement in access to continuing outpatient psychotherapy. Two Southern California representatives commented that Kaiser's behavioral health services improved after the Optum overlay was initiated.

Healthcare facilitators report difficulties accessing providers who are in the insurance network. They make multiple phone calls, don't get a call back, get informed that the provider is not accepting new patients or patients with that insurance. Not everyone can afford to pay out of pocket.

Many campuses reported difficulty finding Spanish speaking providers.

One campus reported that Optum's (Kaiser overlay) reimbursement rate is ~2x that provided by MHN (Blue & Gold). The workgroup lacks detailed information about reimbursement rates across all plans. Reimbursement rates are proprietary and not typically shared with clients. One EAP representative noted that Magellan is the worst insurance company to deal with.

Merced has almost no local providers. Patients typically go to Fresno, Davis or San Francisco.

All agreed that insurance reimbursement was insufficient to induce clinicians to accept referrals. It was unclear if diagnosis (e.g. severe mental illness) affected access problems.

All campuses reported difficulties in finding referrals for teens and children. Everyone agreed that child psychiatry referrals were huge problems and that it was difficult to get psychiatry referrals in general. UC might profitably focus on children’s issues because they are so devastating not just to the child but to the family and because the shortage of practitioners in this area.

Recent events, such as the COVID-19 pandemic, natural disasters, political and/or racial tensions further increase demand. Forty-five percent of UC employees report “a lot of stress” because of the coronavirus pandemic. From 2019 to 2020, the Greenwald survey found that employees rating their health as excellent or very good sharply declined by 19% from 2019 to 2020.²

II.3 Survey data:

Almost half of survey respondents said it was difficult to find any behavioral health provider to meet their needs (Figure 1). Many plan to go outside the network and were concerned about affordability. Privacy concerns do not seem to be a barrier to employees utilizing UCHealth behavioral health providers.

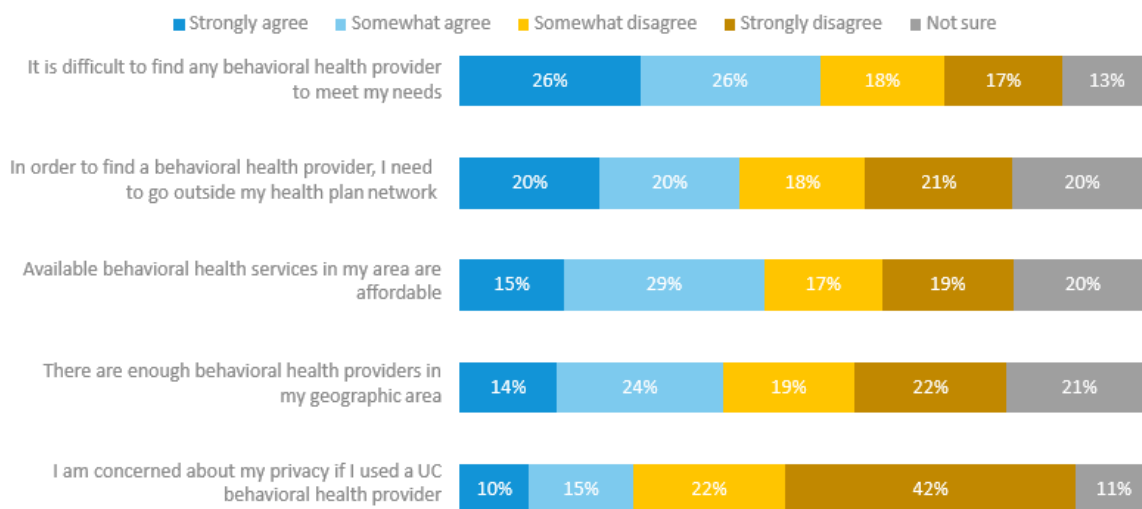


Figure 1: Greenwald & Associates Market Research Firm, 2020

² UC Employee Plan Subscriber Survey: Wellbeing and care seeking, presented 4/16/21 to HCTF, Slide 72

All groups reported an insufficient number of behavioral health care providers in their community (Figure 2).

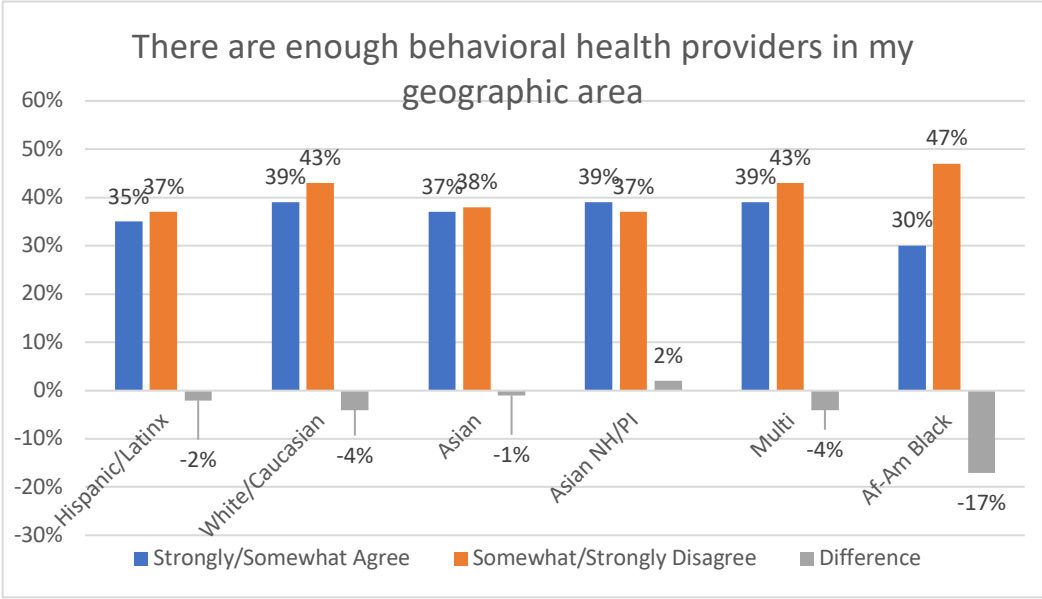


Figure 2 Source: Greenwald & Associates Market Research Firm, 2020

Among employees or family members who needed behavioral health service for themselves, most had to call multiple providers to get an appointment. Nearly 70% of employees needed to make more than one call to get an appointment and nearly 40% needed to make three or more calls to get an appointment (Figure 3). Such problems were particularly pronounced at Merced, UCSF, and Davis, suggesting that geographic factors affect access in ways that are difficult to disentangle (e.g. not likely attributable just to population density).

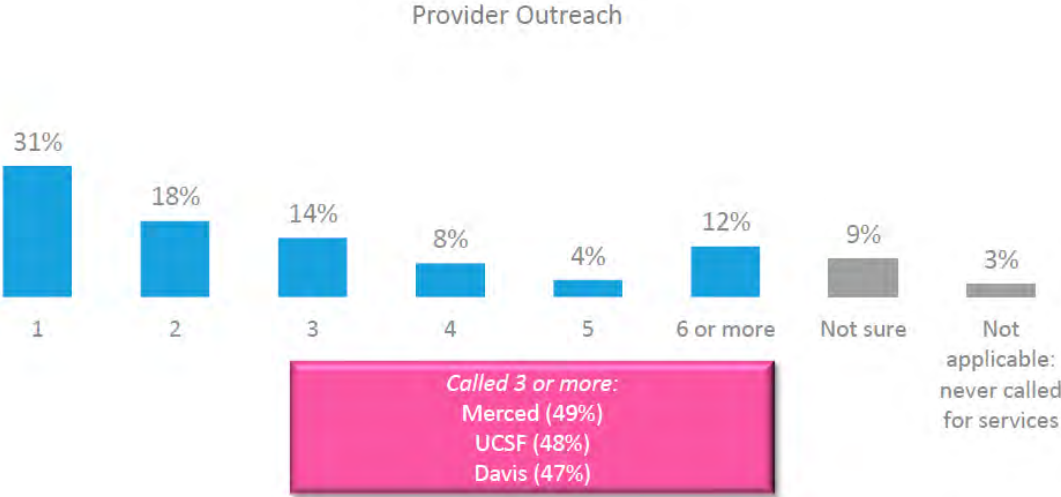


Figure 3 Source: Greenwald & Associates Market Research Firm, 2020

These difficulties accessing care were reported by employees from all educational backgrounds. About a third of UC employees are dissatisfied with the process of getting behavioral health care. Employees reported long wait times to be seen and suggested this needed improvement (Figure 4).

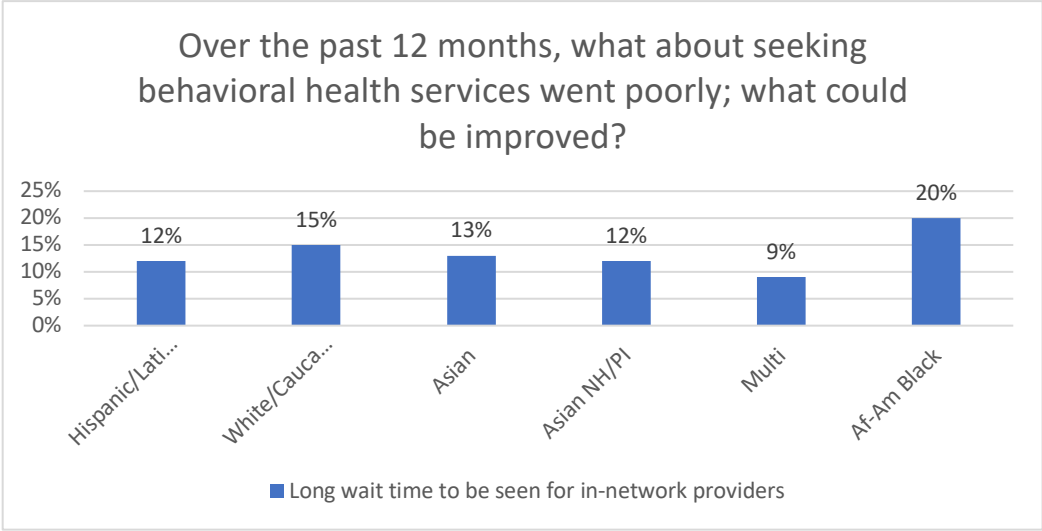


Figure 4 Source: Greenwald & Associates Market Research Firm, 2020

Regardless of pay band, ~50% of UC employees report “it is difficult to find any behavioral health provider to meet my needs.”

In 2020, Health Net provided data on the average number of calls needed to make an appointment with various types of behavioral health care providers and the average number of days to make an appointment (Table 1). Despite the common reports that it is difficult to schedule appointments with psychiatrists, these data suggest that it was even harder to find an available non-MD behavioral health provider. On the other hand, once a provider agreed to see a patient, the wait time until an appointment was reasonable (5 to 8 days).

Table 1: Calls needed to make an appointment

MD		NON-MD	
Avg #Calls	Avg #Days	Avg #Calls	Avg #Days
5	8	9	5

Geographic Variation Reflected by Survey Data

Employees at Merced seem especially pressed to find accessible, available providers; Davis and UCSF academic campuses also stand out as having access issues.

More than 30% of employees at Merced, Davis, UCSF, Santa Barbara, and Berkeley report issues finding any behavioral health provider to meet their needs (Figure 5).

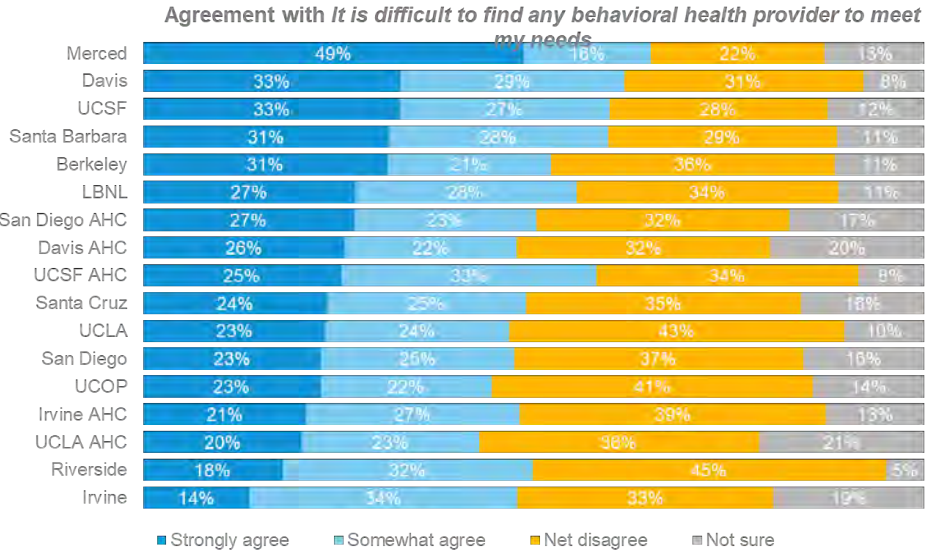


Figure 5 Source: Greenwald & Associates Market Research Firm, 2020

The access issues are so problematic that at least 25% of employees who needed a behavioral health provider needed to go outside their insurance network at Merced, Berkeley, UCSF, LBNL, Santa Cruz, and UCSF medical center (Figure 6).

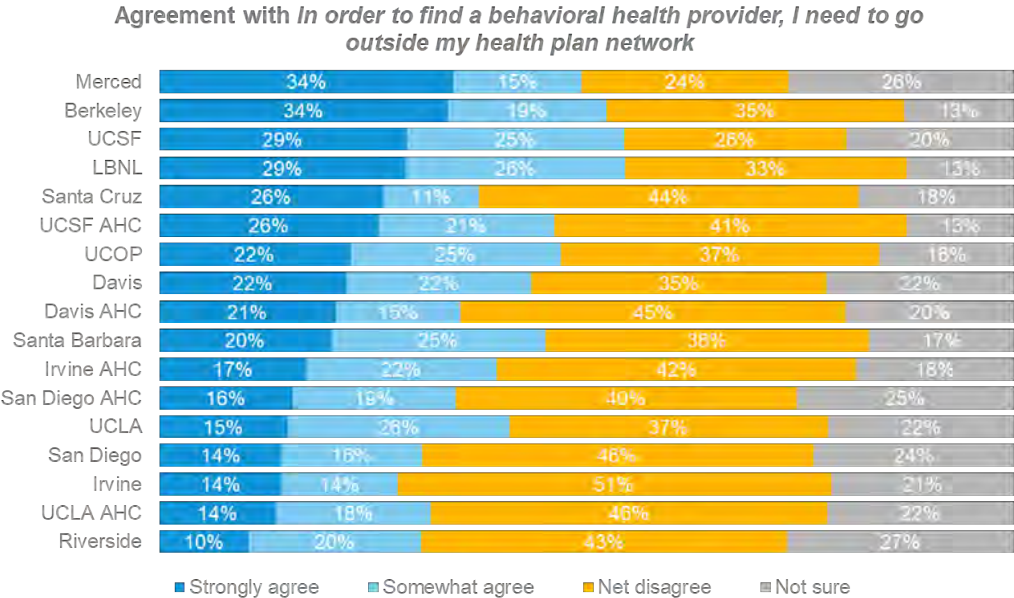


Figure 6 Source: Greenwald & Associates Market Research Firm, 2020

Perhaps related to the out of network utilization, about 40% of employees report that behavioral health services are not affordable in the UCSF, Berkeley, Merced, UCOP, Santa Cruz, Santa Barbara, and LBNL areas (Figure 7).

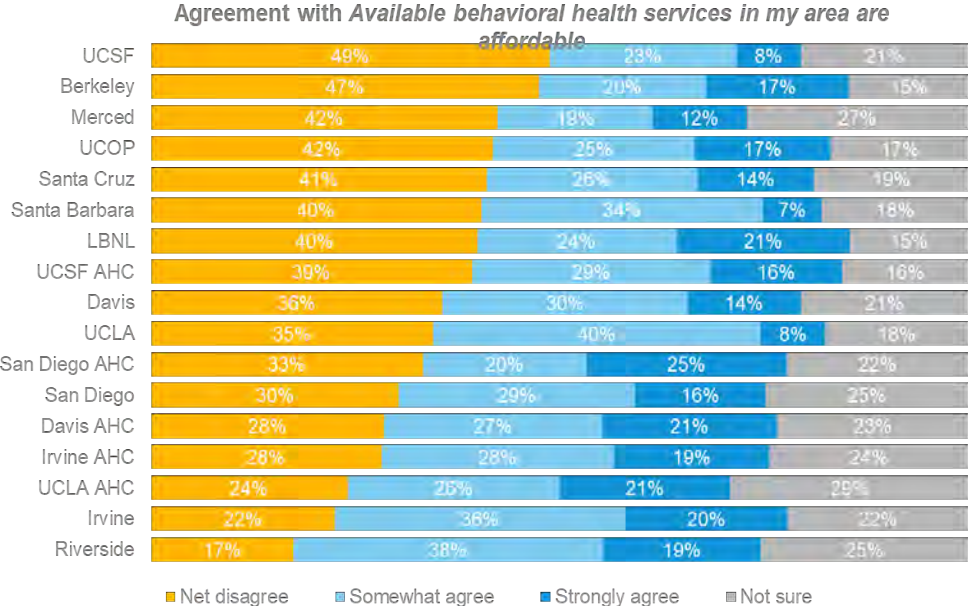


Figure 7 Source: Greenwald & Associates Market Research Firm, 2020

Wait Times for Behavioral Care reflected by survey data

Most UC employees had to wait between 1-4 weeks, between when they called for a behavioral health care appointment and when they were seen (Figure 8).

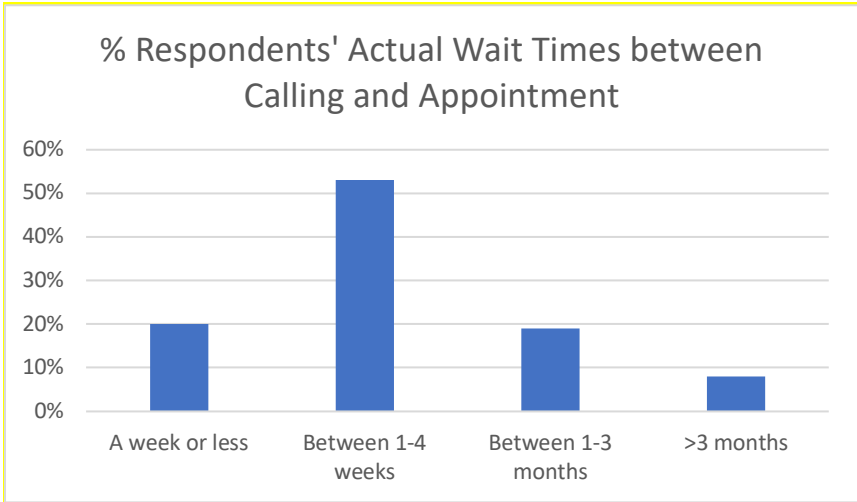


Figure 8 Source: UC Employee Plan Subscriber Survey, wellbeing and care seeking, presented to HCTF 4/16/21, adapted from slide 58

Using common metrics, Greenwald compared the wait times across the various plans (Figure 9). The data defy easy summarization. For instance, UC Care reports the highest percent of appointments seen within a week AND the highest number of appointments that are delayed between 1-3 months.

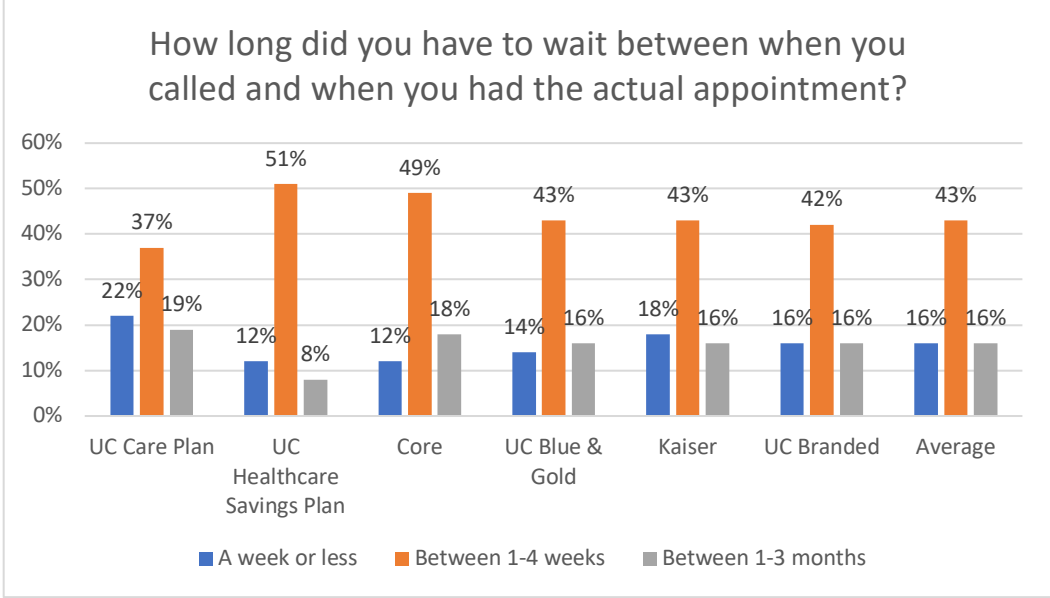


Figure 9 Source: Greenwald & Associates Market Research Firm, 2020

Survey Data Regarding Technological Solutions

Employees prefer in-person behavioral health appointments but are open to a video call or phone call with a behavioral health professional. At present, there is less enthusiasm for using apps or texting, but such approaches may be more appealing to specific groups (see Figure 10, next page).

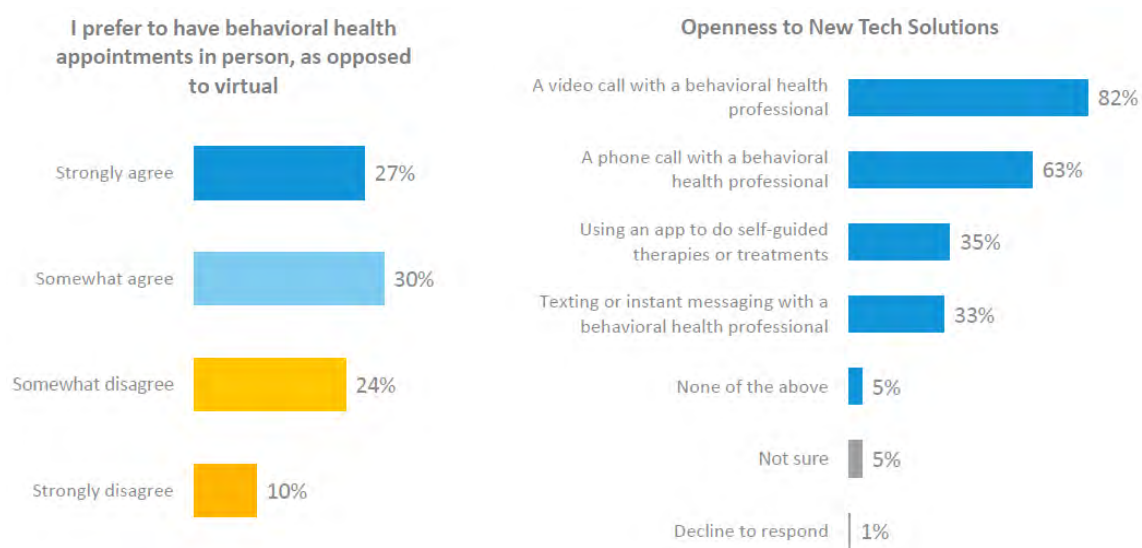


Figure 10 Source: Greenwald & Associates Market Research Firm, 2020

II.4 Evaluating network adequacy:

Behavioral Health Provider Networks

Anthem and Health Net have provided network and utilization data that provides interesting insights into access and ‘ghost’ providers (in-network providers who have seen no UC patients over the course of a year).

Health Net has an overall higher percentage of its network who are UC providers (i.e. salaried by UC) than Anthem, but there are surprising geographical differences (see Figure 11, next page).

UC Behavioral Health Providers as Percentage of Health Plan Networks

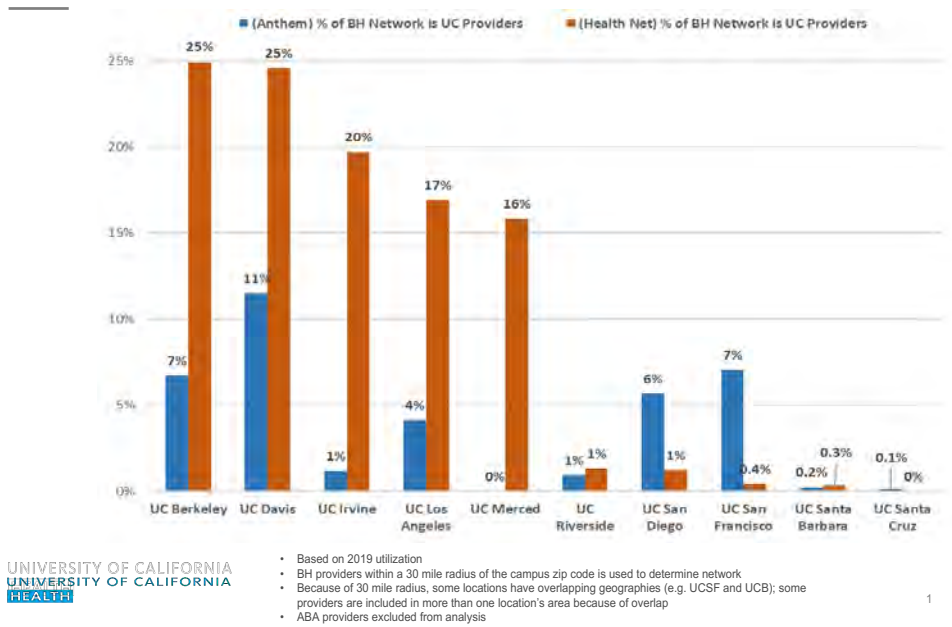


Figure 11 Source: Anthem Health Care Insurance Provider and Health Net Health Care Insurance Provider

Some campuses with health centers have surprisingly low numbers of behavioral health providers in the networks (Figures 12 – 14, following pages). Both Anthem and Health Net have UC salaried behavioral health providers that do not see any of our members. Again, there are differences observed by UC location. It is unclear why the number of these providers is so high, especially in the Health Net Blue & Gold HMO network. They may reflect different contracting strategies. Nonetheless, these data suggest we underestimate the extent of the ghost provider problem.

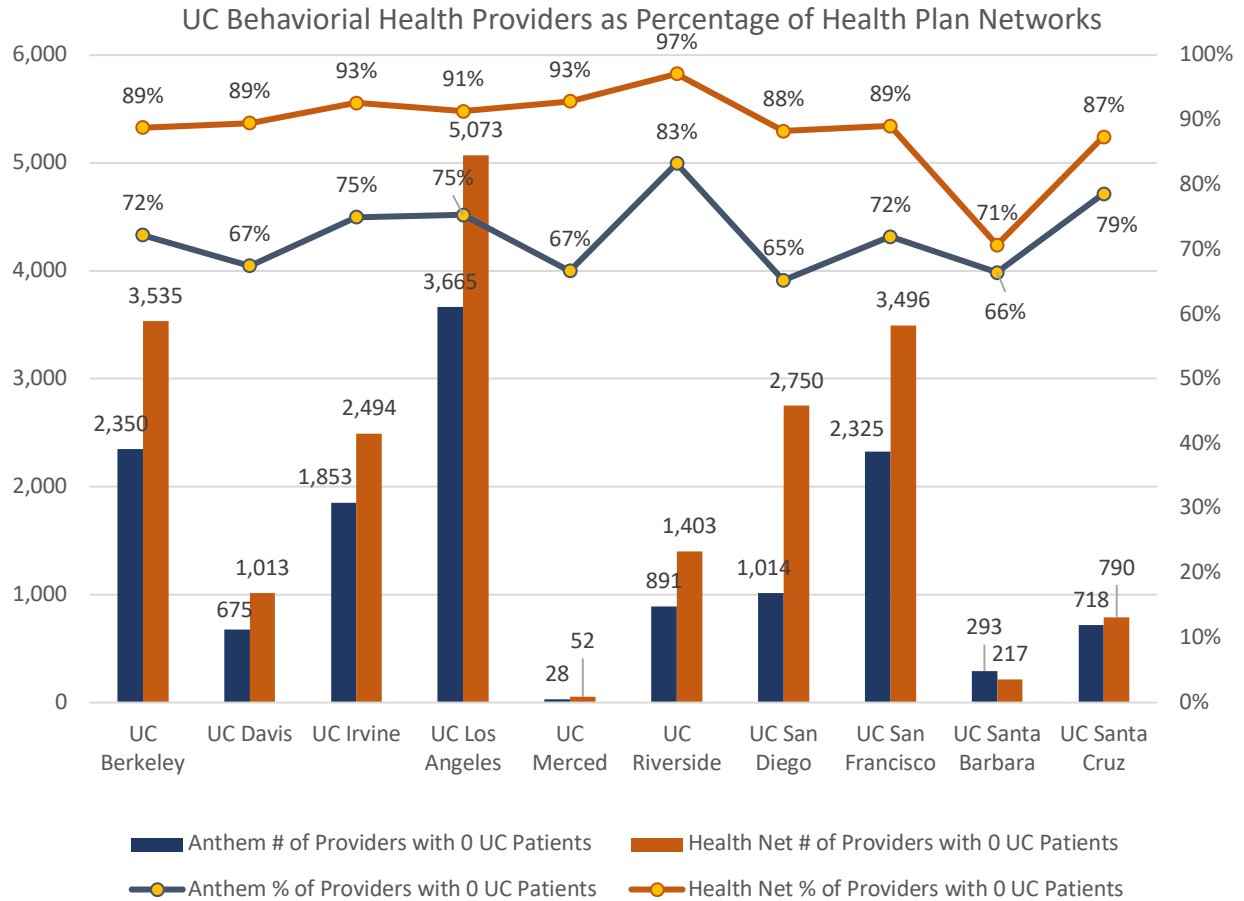


Figure 12 Source: Anthem Health Care Insurance Provider and Health Net Health Care Insurance Provider

In Anthem’s network, UC Los Angeles has the highest number of UC providers with zero UC patients.

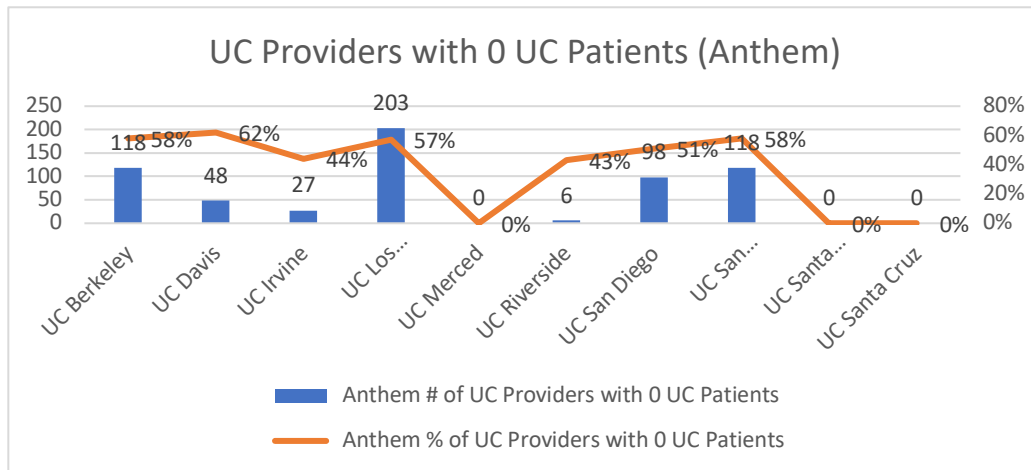


Figure 13 Source: Anthem Health Care Insurance Provider

In terms of Health Net, UC San Francisco has the highest number of UC providers with zero UC patients. On a percentage basis, 60% of UC Riverside providers saw no UC patients.

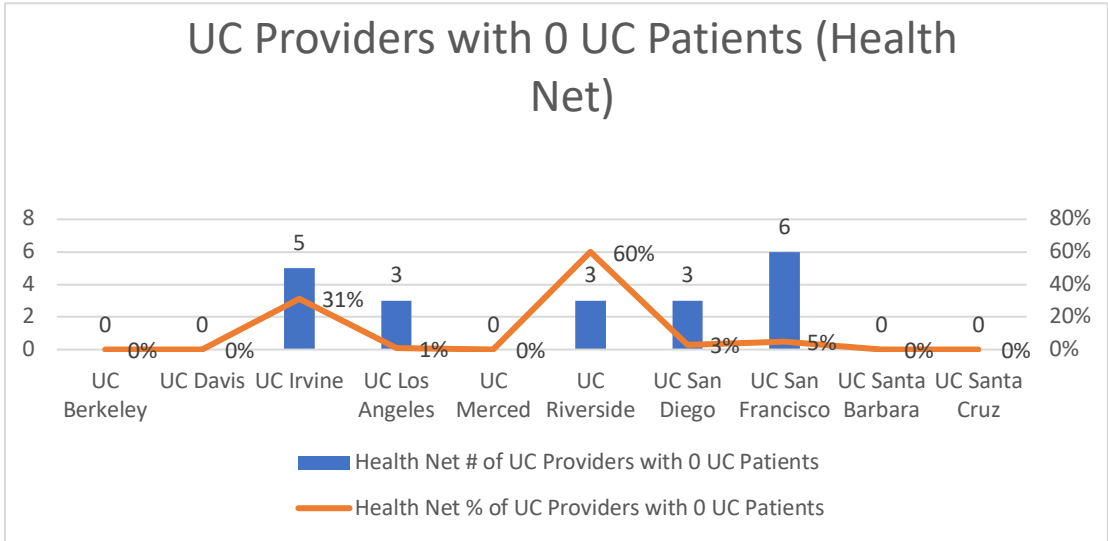


Figure 14 Source: Health Net Health Care Insurance Provider

Such problems are not unique to UC-sponsored plans but reflect that “networks” are notoriously inaccurate indicators of acceptable medical access. The California Department of Managed Health Care contacted 129,786 providers listed in network directories. Six percent indicated no appointments were available. Thirty-one percent refused to even take the survey; 2% were no longer in the plan network; 5% had glitches with the phone number; 9% of providers were no longer in the country; and 1% had retired³. The network inaccuracy rate for behavioral health providers is even worse (Table 2). The table below provides network inaccuracy rates for the Los Angeles area in 2018.⁴

Table 2: Network Inaccuracy Rates

	Overall network error	Network error for psychiatrists
HealthNet	29%	53%
Kaiser	28%	32%
Molina	58%	83%

UC HR conducts the Experience of Care and Health Outcomes (ECHO Survey), which monitors overall plan satisfaction specific to behavioral health services. Plans are required to meet

³ Data from Simon F. Haeder, Penn State, 4/12/21
⁴ Pifer, Rebecca, San Diego sues Molina, Kaiser, Centene’s HealthNet over alleged ‘ghost networks.’ Healthcare Dive, 6/28/21, https://www.healthcaredive.com/news/san-diego-sues-molina-kaiser-centenes-healthnet-over-alleged-ghost-netw/602494/?utm_medium=email&utm_source=rasa_io&PostID=32865725&MessageRunDetailID=5654673390

certain scores under performance guarantees or pay a penalty for missed guarantees. Tables 3 and 4 reflect ECHO Survey results for UC non-Medicare plans for the last three years.

There are intriguing differences between the self-funded and HMO plans. For the self-funded plans, there has been a general improvement in most areas of satisfaction over the three years studied. However overall satisfaction with the behavioral health plan has been low, particularly with HSP. Getting treatment quickly and getting explanations about treatment were also areas for improvement.

Table 3: ECHO Survey Results* for UC Self-Funded Plans

	UC Care			HSP		
	2018	2019	2020	2018	2019	2020
Behavioral Health plan	56%	67%	63%	28%	36%	42%
Counseling and treatment	75%	84%	79%	75%	69%	73%
Getting treatment quickly	61%	55%	68%	51%	49%	60%
How well clinicians communicate	95%	96%	96%	99%	94%	95%
Getting treatment and info	54%	56%	54%	48%	41%	49%
Info about treatment options	40%	41%	37%	25%	32%	26%
Perceived improvement	67%	71%	72%	75%	72%	67%

* Overall ratings of satisfaction with behavioral services
 Note: ECHO Survey excludes Core Plan

In terms of the HMOs (Table 4), Blue & Gold performed better than Kaiser. Kaiser has not demonstrated consistent changes in satisfaction ratings over time. Its counseling and treatment program has been consistently rated least satisfactory of all the health plans studied. Similarly, its ability to provide behavioral treatment quickly was also rated lowest of the group of plans. On the other hand, Kaiser rates higher than self-funded plans on “Getting treatment and info” and “Info about treatment options.” In the crucial variable “Perceived improvement,” the plans are all roughly comparable.

Table 4: ECHO Survey Results* for UC HMOs

	Blue & Gold**			Kaiser		
	2018	2019	2020	2018	2019	2020
Behavioral Health plan			72%	63%	55%	56%
Counseling and treatment			90%	70%	66%	67%
Getting treatment quickly			66%	49%	44%	53%
How well clinicians communicate			96%	91%	89%	90%
Getting treatment and info			65%	61%	54%	57%
Info about treatment options			45%	58%	60%	63%
Perceived improvement			70%	68%	69%	70%

* Overall ratings of satisfaction with behavioral services
 **Behavioral Health integrated with Blue & Gold in 2020

For UC Care, HSP and Core, members have broader access options, given the ability to seek care in- and out-of-network. For HMO plans, access is limited to network providers except in cases of prior authorization or an appeal approval. The alternative is to pay full cost out-of-pocket to non-network providers. Most employees are unable to afford the cost of care outside their insurance plans.

While the Blue & Gold plan is an HMO, its ratings are similar to UC Care. This difference suggests that the extra effort to build the Blue & Gold behavioral health network single source agreements during plan transition and implement related programs to enhance member access was beneficial.

Historically, Kaiser’s reputation of mental health care has been poor with limited access to providers and quality care. Table 4 (previous page) displays survey results for Kaiser from the last three years. In general, satisfaction rates for Kaiser are lower than UC Care and Blue & Gold plans (Tables 3 and 4). While scores have increased slightly from 2019 to 2020, opportunity exists for further improvement on most categories, particularly access to care (Getting treatment quickly) and quality of care (Rating of counseling and treatment). Table 5 provides an overview of Kaiser utilization data. Comparable data for Anthem and Blue and Gold are provided in Tables 5.1 and 5.2, respectively.

Table 5: Kaiser Utilization of Outpatient Services

Period: Jul 2019 - Jun 2020	Kaiser		
Professional Outpatient	Mental Health	Substance Abuse	Total
Average Members			127,668
Claimants	8,979	526	9,505
Member Utilization %	7.0%	0.4%	7.4%
Visits	73,000	2,957	75,957
Visits per 1000	571.8	23.2	595.0
Visits per Claimant	8.1	5.6	8.0

Table 5.1 (next page) demonstrates striking differences in utilization between Kaiser and Anthem. Member utilization rates are >2 times higher in Anthem. Visits per 1000 are roughly 4 times higher in Anthem and visits/claimant are also >2 times higher in Anthem. There are many possible explanations for such differences. They may reflect differences in plan choice in terms of behavioral health needs. At Kaiser, visits per claimant are typically lower than other UC plans as Kaiser’s model focuses on primary care treatment and continuing behavioral therapy treatment is limited. The lower rates of care at Kaiser may reflect: a greater amount of unrecognized and untreated behavioral health problems in that system, the possibility that patients have left the Kaiser system to obtain their behavioral health care elsewhere, or that Kaiser manages its behavioral health in its primary care settings.

Table 5.1: Anthem Utilization of Outpatient Services

Period: Jul 2019 - Jun 2020	Anthem		
Professional Outpatient	Mental Health	Substance Abuse	Total
Average Members			69,904
Claimants	11,211	378	11,397
Member Utilization %	16.0%	0.5%	16.3%
Visits	160,732	2,444	163,176
Visits per 1000	2299.3	35.0	2334.3
Visits per Claimant	14.3	6.5	14.3

Blue and Gold (Table 5.2) is similar to Anthem in terms of visits per claimant but intermediate between Kaiser and Anthem in terms of member utilization.

Table 5.2 Blue and Gold Utilization of outpatient Services

Period: Jul 2019 - Jun 2020	Health Net		
Professional Outpatient	Mental Health	Substance Abuse	Total
Average Members			111,316
Claimants	11,829.00	281.00	11,942.00
Member Utilization %	10.63%	0.25%	10.73%
Visits	161,145	3,507	164,652
Visits per 1000	1,448	32	1,479
Visits per Claimant	13.62	12.48	13.79

To address the limitations of Kaiser’s ongoing behavioral therapy program, UC implemented a Kaiser overlay through Optum in 2008. Optum offers 14,000 clinicians in CA. The Overlay results in some differences in care delivery (Table 6) as compared to Kaiser. The visits/patient are 35% higher in the overlay than in Kaiser. Of the Kaiser patients who require behavioral health services via Kaiser or Optum, the Overlay provides care to about 25%. Survey data suggest greater patient satisfaction with the Optum Overlay (Table 7) than with Kaiser (Table 4).

Table 6: comparing Kaiser and Optum

Outpatient (In-person and Telehealth)	Kaiser 7/2019 – 6/2020	Optum (Kaiser Overlay) 2020
Average Members	127,668	130,199
Claimants	9,505	3,477
Member Utilization %	7.4%	2.67%
Visits	75,957	37,829
Visits per 1000	595	309.40
Visits per Claimant	8	10.88

Comparing the plans, Anthem has the highest utilization (16%) and visits per claimant (14). Blue and Gold reports 11% utilization and 14 visits. Kaiser has the lowest utilization—7% and 8 visits. The Kaiser Optum overlay has low utilization—2% but a higher number of visits/claimant (11) than Kaiser.

Table 7: ECHO Survey Results for Optum

	Optum (Kaiser Overlay)		
	2018	2019	2020
Health plan	66%	64%	71%
Counseling and treatment	76%	75%	83%
Getting treatment quickly	63%	50%	66%
How well clinicians communicate	96%	97%	98%
Getting treatment and info from plan	58%	60%	59%
Info about treatment options	43%	40%	37%
Perceived improvement	79%	75%	77%

* Overall ratings and composite scores

Over the past several years, UC HR has placed pressure on Kaiser to address shortcomings on its behavioral health program. UC HR has partnered with the Purchaser Business Group on Health (PBGH-formerly known as Pacific Business Group on Health) to address issues and identify opportunities for better access and outcomes in this area.

In response, Kaiser has taken several measures to address these issues. Recent actions include:

- **Staffing:** As of July 2019, Kaiser added 300 fulltime mental health positions across California, including >180 new providers in Psychiatry and Addiction Medicine services.

On the other hand, the number of mental health clinicians leaving Northern California Kaiser has doubled in 2022, compared to the previous year.⁵

- **Training the next generation:** Kaiser is investing \$50 million over the next 3 years to increase individuals entering mental health care professions. Specifically, Kaiser will offer training opportunities statewide for over 300 trainees each year, including residency training programs in psychiatry, and training opportunities for master’s level and pre- and post-doctoral level mental health providers. Kaiser is also interested in graduating bilingual and/or diverse students who reflect community needs. Kaiser’s new medical school, the Bernard J. Tyson School of Medicine, emphasizes behavioral health.
- **Facilities:** Kaiser has invested over \$700M to expand and update mental health care offices, with the goal of increasing care, accessibility, convenience, comfort, and privacy. Mental health and wellness facilities have been opened in Oakland, San Francisco, Watsonville, Scotts Valley, Modesto, Riverside and Los Angeles.
- **Telehealth** is built into Kaiser’s integrated care system. Providers are typically the patient’s regular provider. All mental health clinicians can conduct telehealth appointments when appropriate. Their tele-psychiatry programs offer same day or next day care. Recently, Kaiser has announced its plan to offer Ginger to its membership in late 2022-2023. Ginger provides mental health coaching via Chat
- **Self-management tools:** Kaiser has introduced a digital self-care portfolio which includes myStrength and Calm apps for members to help support mental health and emotional well-being. These tools are offered at no additional cost to members.

Kaiser and the Kaiser Overlay have established standards for appointment access time (see Table 8 below).

Table 8: Appointment Standards for Behavioral Health

	Kaiser	Kaiser Overlay via Optum
Emergent	Not provided	6 hours
Urgent	48 hours	48 hours
Routine	10 days	10 days

2018 Regional average, not UC specific

Both Kaiser and Optum report adhering to these standards. Kaiser reports 96% of patients are seen within 48 hours for urgent care and 83-91% are seen within 10 business days. Optum reports 100% of patients are seen within 6 hours for emergent and 48 hours for urgent care. Statistics for Routine care were not provided by Optum. It is unclear why Kaiser reports excellent access time data whereas their patients report the most problematic access times.

⁵ Kaiser mental health workers signal strike in Northern California, CalMatters, August 2, 2022, https://calmatters.org/health/2022/08/kaiser-mental-health-worker-strike/?utm_source=CalMatters+Newsletters&utm_campaign=58bc0d3d16-WHATMATTERS&utm_medium=email&utm_term=0_faa7be558d-58bc0d3d16-151356172&mc_cid=58bc0d3d16&mc_eid=52de4f780e

Kaiser senior management met with the HCTF at its April 2022 meeting to discuss the quality and availability of their behavioral health care. Kaiser's perspective was that their model is both effective and appropriate, and that their lower rate of visits was a feature of their integrated model in which more responsibility falls to primary care physicians. They emphasized the developments to expand and improve care outlined in the bullet points above. UC participants in the discussions came away with the impression that there is a disconnect between Kaiser's perception of their behavioral health services and what we have learned from extensive questionnaires and anecdotal reports. These sources reveal dissatisfaction with Kaiser services relative to services provided under other UC health plans.

Going forward, it would be beneficial for UC to have on-going dialogue with Kaiser to explore this disconnect and to improve the satisfaction of UC enrollees in Kaiser with their behavioral health care. It would also be beneficial to find avenues for sharing data, and especially to resolve the differences between the ECHO data and what is generated by Kaiser so that an accurate picture of the effectiveness of treatment can be ascertained.

III. Potential solutions

III.1 UC Health Centers and departments of psychiatry

Although it will likely require many different solutions to solve this problem, the UC psychiatry departments could be helpful for those campuses with medical schools. On the other hand, most UC psychiatry departments focus on specialized care and clinics rather than primary care psychiatry. Nonetheless, the following ideas should be investigated:

- Working with hospital administrators to better engage UC departments of psychiatry in providing care could be helpful.
- Many campus EAPs have links with the departments of psychiatry. These links in both adult and child psychiatry could be strengthened to facilitate local referral.
- One step towards increasing care provided by psychiatry departments would be to have a special appointment contact line for UC employees.
- Psychiatry departments could be incentivized to take more volume and guarantee more rapid access to appointments.
- Most of the UC Health campuses have clinics that offer combined medical and behavioral health care. Regrettably, it appears that these various clinics do not communicate with each other across the UC system, thereby depriving UC of learning from the various campus efforts. For instance, it is unclear how much institutional subsidies each requires. If such integrated clinics demonstrate improved access to high quality behavioral health care, their funding should be increased. If appropriately

subsidized, they might then be able to accept the lower level of reimbursement provided by our plans.

- Given that primary care providers are the frontline for encountering behavioral health issues, expanded training in behavioral health would be useful in internal medicine and family medicine residencies.
- Given the dire shortage of MH practitioners, it would seem prudent for UC Health to look at expanding its training programs in psychiatry. Expansion of training programs in clinical psychology should also be explored, although there are different institutional and regulatory issues in this regard. Finally, UC should explore instituting masters level training programs in counseling psychology and social work and/or clinical training sites, either on its own or in conjunction with the CSUs or with California Community Colleges.

III.2 Prevention

It is important to focus on an approach that not only offers screening services for emotional/behavioral health disorder, but also incorporates key elements of prevention. However, limited access to any behavioral health services because of the current gap in available programs and the statewide shortage of available behavioral health practitioners, seriously threatens the development of prevention services. The committee proposes that the following be considered:

Employee Assistance Programs (EAP)

The UC Employee Assistance Program (EAP) provides a significant amount of “in-house” behavioral health care services. Because their mission is to provide direct care, which includes screening and early treatment, EAP is positioned to provide prevention services. However, because of the high demand, EAP is rarely able to provide ongoing care for chronic or high risk, high acuity conditions. Most campuses use EAP to deliver short-term care to UC employees and their families. However, this does not include child services.

UC Merced does not have its own EAP and instead contracts out to Insight EAP, as an external resource. Insight EAP provides 3 sessions/6 months for employees and family members. Beyond that, they refer to their sister company, Comprehensive Behavioral Health. No data were presented that document whether this Merced arrangement provides better access. Other campuses that contract EAP services include UC Santa Cruz (Optum), Hastings (MHN), UC Riverside and UC Path (ComPsych) and UC San Diego (Optum). UC Irvine has in-house EAP and additional support from ComPsych.

In addition to direct care services, EAPs provide extensive training to departments on stress and provide critical incident support for catastrophic events. One campus EAP program does threat assessments and, when necessary, facility police welfare checks. An advantage to incorporating EAP into future strategic planning is that EAPs know the culture of the university.

EAP programs may offer an alternate care delivery path, other than that provided as part of the insurance carrier's network. They also provide support groups, which have been thought to be very helpful.

There appear to be several opportunities for strengthening the benefits from these EAP programs. For campuses with Health Sciences programs, increased communication between EAP and psychiatry programs might facilitate referral for chronic and/or higher acuity services⁶. The EAP programs may also establish better communication with UC-contracted insurance programs. UC San Francisco reports that Anthem has been pro-active in building relationships with their EAP. Another opportunity is to increase EAP's participation in campus HR and staff education. Expansion of EAPs role would likely require increasing EAP staff numbers. We received no data about the costs of expanding the EAP program vs the benefit in terms of greater access numbers or decreased wait times.

Community Behavioral Health Clinicians

UC should develop and enhance the referral base for UC faculty and staff requiring behavioral health services. UC should consider initiating programs such as clinically oriented continuing medical education (CME) courses/seminars and telehealth case conference supervision such as that modeled at the University of New Mexico (UNM) Project ECHO (Extension for Community Healthcare Outcomes). Project ECHO⁷ is a program based at UNM designed to enhance community clinicians' ability to evaluate and treat conditions that may be prevalent but require specialist referral or input for adequate and appropriate care. The program pairs community clinicians with UNM medical faculty specialists/subject matter experts via live video group case conference format where enrolled community clinicians can present difficult and/or confusing cases for specialist input. The program is being widely disseminated for several clinical conditions.

III.3 Network

As discussed above, there are widespread problems accessing behavioral health care in all the networks. UC might provide better education on access during open enrollment or in written material.

⁶ To address the significant increase in demand for Behavioral Health Services during the Covid19 pandemic, UC San Francisco partnered with EAP to implement the UCSF Faculty, Staff and Trainee Coping and Resilience Program (COPE) which featured a chat based behavioral health screening, extensive web-based materials (self-management Apps and curated content), in-person (via telehealth) navigator and rapid access (appointment scheduled within 48 hours) to Department of Psychiatry treatment services.

⁷ [https://urldefense.com/v3/https://hsc.unm.edu/echo/ ;!!LLK065n_VXAQ!1TheHdRifbli73aZ2gdmwBA8ZbVyQuaQduKO14w6VtWGiPoYYCwAfxFmRSOGFjQLL-I\\$](https://urldefense.com/v3/https://hsc.unm.edu/echo/;!!LLK065n_VXAQ!1TheHdRifbli73aZ2gdmwBA8ZbVyQuaQduKO14w6VtWGiPoYYCwAfxFmRSOGFjQLL-I$)

Pediatricians and primary care doctors are largely unaware of local mental health providers. They advise patients to call their insurance companies for referral, but the interface with the insurance company is difficult. Do the intake workers take enough of a history to know how to make a referral? Do they help with the referral and follow through? Some companies in essence offer a behavioral health navigator. It would be useful to learn how each network handles this and any supporting data. The navigator approach has the potential to improve patients' ability to find a clinician rapidly.

The insurance companies need to make more single-payer agreements in areas where there is shortage or evidence of network failure (inability to find a clinician despite numerous calls). Fees need to be structured to increase access. For instance, clinicians might be incentivized to treat larger volumes of UC employees.

In future contract negotiations, UC should query bidders about the steps they propose to monitor availability from providers in their networks and correct problems. UC should explore increasing the penalties when insurance providers fail to meet agreed upon access and quality measures.

Quality measures are difficult in behavioral health care because they largely rely upon patient related outcomes as opposed to laboratory or physical findings. In an environment where there are not enough providers at all license levels, particularly in some parts of the state, there is no inherent connection between increasing access to care and making sure that the care provided is of high quality. Paying providers more so that access is improved will increase costs without assuring that the care is effective. Increasingly, health systems are employing measurement-based care, using instruments like the PHQ9 to examine depression levels when treatment begins and re-assessing at a defined point in the future to see if there has been adequate improvement. Additional quality measures may examine, for instance, if there is evidence that patients are adhering to prescribed medications. Network adequacy can also be characterized by provider cultural competency. To incorporate such new quality measures, the best approach might be to convene a committee of experts representing psychiatrists, PhD psychologists and masters level practitioners to derive industry recognized metrics that could be employed that would be acceptable to clinicians.

It seems a major missed opportunity for UC not to capitalize on its psychiatric clinics as care providers for UC employees. On some campuses, there are few clinicians even in our networks. Furthermore, there should be a process whereby a UC employee can readily schedule an appointment at a UC facility, perhaps a special phone in line.

UC should provide consultation and expertise to the Legislature and state regulatory agencies (e.g. Department of Managed Health Care) concerning evaluation of state regulations regarding network adequacy.

III.4 Telehealth

Telebehavioral health offers potential advantages for mental and behavioral health provision, including affording greater access to providers, and shortening time to appointments. For student mental health services, telebehavioral health has increased the number of patients seen by approximately 20%. A further advantage of telehealth is that it lowers the rate of no-shows. Telebehavioral health also offers potential advantages for underserved areas where there are few clinicians and for shortening travel time to appointments.

UC Health has formed a systemwide collaborative on telemedicine, primarily focusing on student mental health. The technical aspects of telehealth can work well, although the EPIC interface has been troubled by dropped calls and technical interface issues. Systemwide has been trying to build a platform whereby students can access any mental health provider within the UC system, regardless of campus. If successful, this would have the potential to expand service via a shared provider network interacting via EPIC. Notable problems have emerged from cross-credentialing across the various campuses. This may be an instance of trying to develop an overly ambitious platform.

Of models for expanding telehealth, asynchronous interaction may be promising. On this model, a mental health professional performs and records a structured interview with the patient, and then reviews the interview with a psychiatrist or psychologist. The patient is then referred to a therapist with therapeutic suggestions. This approach could work well in the UC context if, for example, a UC department of psychiatry partnered with community clinicians.

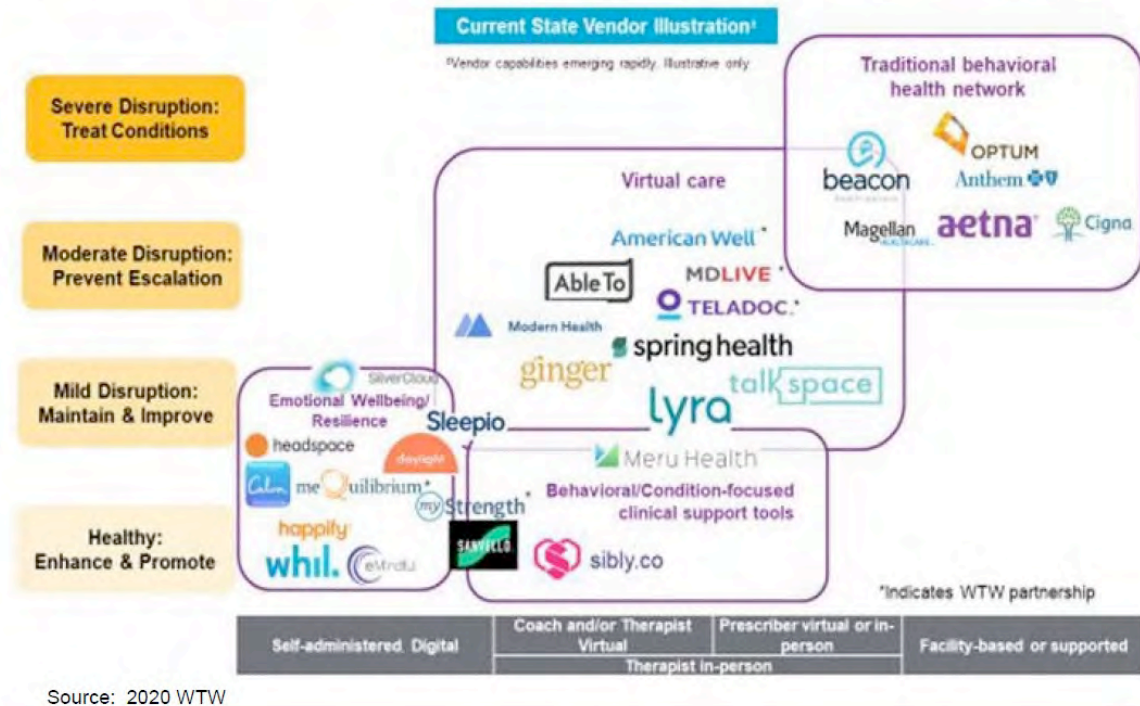
Telehealth will play a significant role in the future provision of mental and behavioral health care, especially given the experiences with telehealth during the Covid pandemic. It has the potential to help improve access issues, especially in areas where the number of local providers accepting UC insurance plans is small. But it is not a panacea for all access problems. Many people prefer face-to-face therapeutic interactions, which may be more effective for treating certain conditions. Additionally, telebehavioral health may not be appropriate for treating younger children. Given the urgency of access issues, it is important to explore how to optimally implement telehealth where it can be most effectively utilized.

We need to explore further telebehavioral capabilities. Are we getting full utilization? Can it do more? Given that it still does not solve reimbursement gap, how can it solve access problems?

III.5 Digital Point Solutions

Some organizations have taken a two-pronged approach by offering a traditional behavioral health model (UC's current) and a second vendor to address less severe problems. A variety of solutions have surfaced in the market to help bridge the gap for behavioral health services. Figure 15 (next page) displays new entrants, the mode of service and level of disruption in the behavioral health market.

Solutions to Provide a More Complete Behavioral Health Approach



UNIVERSITY OF CALIFORNIA Systemwide Human Resources Health & Welfare Benefits

1

Figure 15

Such wellness programs can be an important adjunct to behavioral health care. With the widespread availability of digital platforms (smartphones, iPads, etc.), numerous companies provide a variety of interventions digitally that range all the way from digitally based psychotherapy to text-based coaching on stress, sleep, and resilience. Some programs even target patients with specific needs (e.g. eating disorders).

In 2021 and 2022, UC engaged in a careful RFP process to examine if digital point solutions might promise improved access through digital coaching and online therapies. The RFP evaluation team was favorably disposed to these platforms, particularly if they employed careful tracking of access and efficacy. Subsequently, the ESC approved adding one of these programs for employees but was also concerned about the overall costs for the university and employees. Regrettably, the University encountered some significant regulatory hurdles during early-stage implementation, and this addition will not be possible in calendar year 2023.

III.6 Reimbursement of Providers

While we lack explicit data, we surmise that insurance reimbursement for psychiatrists and psychologists is substantially below what they could be paid by patients out of pocket and not billed through a health plan. We have no data if reimbursement is proportionally better for

master's level clinicians, but the widespread problems with access suggest that reimbursement is relatively poor for all behavioral health clinicians. We need to look at reimbursement more broadly—psychiatrists, psychologists, nurse practitioners, masters level counsellors. In areas of critical shortage such as child psychiatry, reimbursement needs immediate attention.

We analyzed data to assess the prices and quantities for behavioral health care, focusing on services conducted in-network as compared to out-of-network. Note that our analysis focused on visits to providers and did not consider other relevant domains of behavioral health (such as medications or hospital visits), which may merit subsequent attention.

In the UC-Care and the HSP plans, while many employees received care out-of-network, the cost to the plan for those out-of-network (ON) visits was substantially lower than for the in-network visits (IN). For UC-Care, total spend on behavioral health in 2020 was approximately \$18.4 million, with \$16.1 million coming from IN spending and \$2.3 million coming from ON spending. This somewhat masks the fact that many patients receive care ON. In 2020 there were approximately 45,000 ON visits under UC-Care and approximately 109,000 IN visits. Thus, roughly 30% of all UC-Care patients receiving behavioral health care received that care ON. It should be noted that the HMO plans do not have ON coverage. Furthermore, because there is no reimbursement from the HMO plan to the subscriber for ON care, such utilization is not tracked.

Average UC-Care plan spending on ON care was \$51 per visit while average spending on IN care was \$159/visit. For ON care, UC-Care reimbursed 50% of the reasonable and customary charge, suggesting that employees paid at least \$51 per visit on average, and perhaps substantially more due to balance billing (where patients pay the remaining gap between the provider charge and the insurer usual and customary charge). We do not have data on the typical provider charge for ON care in this market, so can only note that the \$51 per visit per patient on average represents a lower bound on patient costs. For IN care, patient cost-sharing was substantially lower. To the extent that we could assess these trends through part of 2021, they remained similar in the UC-Care plan.

We examined these metrics for the HSP plan and found similar proportions of patients going ON and similar differences in plan costs and member costs. The HSP plan metrics are conditional on a patient receiving care. On average, fewer patients in the HSP plan (as a fraction of overall patients) use behavioral health care, suggesting consumers selecting into that plan may have lower mental health needs than those who select into UC Care.

Further analysis of ON vs. IN reimbursement rates might be fruitful as one tool for expanding access to behavioral health. While provider capacity in the system is tight, it may be possible on the margin to improve UC member experiences by changing reimbursement rates. More analysis is needed on this front. How would overall plan costs change with an increase in the ON reimbursement rate for patients? Such a change might bring ON care more in line with IN care from a patient cost standpoint, which would lower patient burden. However, such a change may incentivize patients to seek care out of network and providers to drop from the

network. It was not obvious that increasing the proportion of ON claims paid for patients (relative to the usual and customary charge) would meaningfully improve patient experiences or help access. It would be helpful in the future to gain more information on the typical usual and customary charges paid to providers ON, and how that compares to the total charges to ON patients.

Overall, we found that many patients go for ON care and, in doing so, have a higher cost-sharing burden. They pay more per visit, potentially substantially more, depending on differences between the usual and customary charge for ON visits and the actual charge, but we don't currently have such data. We also lack data on whether the higher cost burden causes patients to self-limit care, resulting in less effective or less enduring health outcomes. Our analysis suggests that while increasing ON cost-sharing for patients could help lighten patients' financial burdens, it might not have a meaningful impact on patient access to care and could have unintended consequences such as incentivizing patients to move from IN to ON care, or incentivizing providers to drop out of the network. This is an area where, with additional data, we might be able to make strong recommendations for different policies related to reimbursement and cost-sharing. We recommend obtaining such data.

One UC outpatient psychiatry clinic reported that it has preferred referral arrangements (i.e. quicker appointment times) with certain groups of patients. With these contracts, the reimbursement levels are better, which is a cost for the insurer. On the other hand, the no-show rates are lower, thereby saving money. Such models should be generalized for UC employees at all campuses with psychiatry or psychology clinics.

Special contracts can also be written to facilitate reimbursable ongoing care when delivered by a senior trainee such as a resident or fellow.

Stated baldly: None of the insurance companies pay enough to attract anyone except new clinicians. Testimony from Davis reported that when Optum increased their rates by 15% a couple years ago, it improved access. Nonetheless, the group was unsure that all problems would be addressed by increasing fees paid to clinicians or decreasing "friction" to providers. Some in the group worried that this would greatly increase premiums and render UCCare less competitive. Increasing reimbursements across the board may be a relatively coarse way of addressing the problem and may not guarantee access to quality providers.

Given that ~10% of UC employees are receiving mental health services within UC, the group thought it would be helpful to assess how UC could support community practitioners in such a way that they would improve their access for referral (e.g. CME courses or ongoing group supervision of community providers).

We are less able to collect data from Kaiser than from the self-funded plans. Kaiser has either been unable or unwilling to provide the same amount of data as is available through the self-funded plans where fewer restrictions on information flow apply. We need to explore how we might engage with Kaiser so that we could obtain a clearer picture of their programmatic

efforts and their results. As noted earlier, we need to review Northern and Southern California Kaiser separately, given their differences in organization.

It would be helpful to meet with DMHC to learn about new developments in establishing meaningful metrics for “networks.” Similar discussions could be held with the California Health Benefits Review Program (CHBRP), particularly if the conclusion was that a revision was necessary in state legislated policies.

III.7 Carving out?

Historically, UC offered carve-out behavioral health services through Optum for all medical plans, including a Kaiser overlay. This allowed UC employees and their eligible dependents consistent access and quality care across plans. Additionally, having one vendor provider for behavioral health services to systemwide UC enabled aggregate reporting capabilities for a holistic approach in identifying issues and opportunities for enhancement.

During the last several years UC transitioned behavioral health services to the medical plans in the hopes that integrating behavioral health with medical plans would produce higher quality care and a better member experience. Currently Blue & Gold members receive services through HealthNet’s MHN, PPO members have services through Anthem and Kaiser services its own members with internal and third-party providers. UC continues to contract with Optum to supplement Kaiser’s program.

Plan metrics on behavioral health have been limited to determine whether integration has been effective. Based on Greenwald and ECHO survey results, access and quality care continue to be problematic. A recent RFP examined whether a carve out of behavioral health would better serve UC. The network disruption entailed by such a carve out was deemed unacceptable. However, if the status quo integrated systems do not improve their access, we may need to revisit whether a carve out might serve us better in the future.

III.8 Responding to innovative treatments

While this report has focused on access issues, the workgroup noted that additional behavioral health metrics need to be tracked in the future. Some of the newly approved and more invasive therapies for treatment resistant depression are costly (ketamine, transcranial magnetic stimulation). Other emerging treatments such as therapist-guided treatment with psychedelic compounds may prove costly and effective. All these approaches may bring near term costs but may help reduce overall behavioral health care costs in the long run. It will be important to monitor how the various insurance programs handle treatment authorizations in these expanding areas.

III.9 Generalizability to retirees?

The large datasets employed in this report focus primarily on active employees. While there is no reason to expect that experiences are different amongst retirees, this needs to be verified particularly because of the difference in health insurance. In certain markets, behavioral health

providers are increasingly not participating in any insurance plans (including Medicare). This increasing non-participation rate needs to be tracked and will likely form the next emerging challenge in behavioral healthcare delivery for the University of California.

IV. Next Steps and Recommendations

UC Health needs to review with campus academic health centers if they can address the access issues through special contracting, access phone numbers or integrated delivery of behavioral health and primary care services

The Health Care Task Force should meet with representatives of DMHC to discuss problems with defining and regulating network adequacy.

The Health Care Task Force should meet with executives from existing insurance companies to discuss how they are monitoring network adequacy and their plans to improve it.

Although access and affordability issues unquestionably exist, it is less clear where the greatest gaps exist; i.e., do some employees & dependents experience greater gaps than others? We need a more “granular” understanding of the gaps.

The University should examine whether and how the insurance plans create barriers to access or duration of care at the approval and/or appeals processes. Does the insurance administrator limit care access recommended by clinicians and if so under what circumstances and what is the motivation (i.e., limiting cost impacts to the plan, or a desire to “spread availability” of limited resources)? Do these practices serve our employees correctly? Does benefit design impact accessibility?

The University should examine how its training programs for behavioral health clinicians can be expanded.

The University should develop metrics for assessing quality of care and access that could be deployed consistently across all the care systems used by its employees, families, and retirees.

The University should resume considering digital point solutions for calendar year 2024.