Strategic, financial benefits

Officials say the strategic and financial benefits of the transaction also include:

• Broadening and deepening Centene’s whole-health capabilities at a critical time. The sickest 5% of the population consume 50% of health care spending and Magellan Health’s behavioral health, specialty health and pharmacy offerings focus on the portion of this spend that is addressable.

• Advancing Centene’s specialty care and Health Care Enterprises platforms. The transaction brings additional scale in the company’s growing specialty care division and complements Centene’s evolving Health Care Enterprises portfolio, aligned with delivering the latest technologies and services across the full spectrum of its members.

• Value creation for shareholders. The acquisition will create attractive opportunities to grow Centene’s specialty care business with enhanced services, new product development and additional third-party relationships. Centene expects the transaction to be slightly accretive in the first full year and deliver low-to-mid-single-digit percent adjusted earnings per share accretion from the transaction by the second full year, including approximately $50 million in annual net cost synergies projected by the second full year. The net synergies are in addition to the cost-reduction plan of $75 million already initiated by Magellan Health.

According to officials, should the acquisition be finalized, Magellan will continue to operate independently under Centene’s Health Care Enterprises arm.

Ken Fasola, CEO of Magellan Health, and other members of Magellan Health’s leadership team have agreed to join Centene to provide continuity to Magellan Health’s strategy and leadership, according to a news release. Centene and Magellan expect the deal to close in the second half of 2021.

Readers remain optimistic in 2021 despite COVID-19 challenges

Mental Health Weekly readers continue to weigh in on what awaits them in the new year. Here are more of their comments:

Rob Todaro, communications manager, The Trevor Project:

Since the onset of COVID-19, the volume of youth reaching out to The Trevor Project’s crisis services for support has increased significantly, at times double our pre-COVID volume. And in preparation for physical distancing, we underwent a rapid, massive tech transformation to move our physical Lifeline call centers in New York City (and Los Angeles) to completely remote operations for the first time ever — to ensure the safety of our staff and that our crisis services remained uninterrupted and 24/7 for LGBTQ youth in crisis.

We will continue to utilize best-in-class technology and implement new artificial intelligence applications to scale our impact, train more crisis counselors and save more young LGBTQ lives.

And here’s a relevant statement from Amy Green, Ph.D., vice president of research for The Trevor Project, on the impacts of COVID-19 on telehealth: “COVID-19 has highlighted vast disparities that exist within the U.S. mental health care system, while also demonstrating that mental health care can be effectively provided via telephone or videoconferencing when necessary. The advancements in telehealth services prompted by the pandemic have expanded the ability for those in need to receive care and should be adopted and expanded upon long term.”

Ron Manderscheid, Ph.D., president and CEO, National Association of County Behavioral Health and Developmental Disability Directors; executive director, National Association for Rural Mental Health:

We have great expectations for 2021! The new year will be much, much better than 2020 was.

As COVID-19 vaccinations multiply to foster a more promising future, the precipice of a behavioral health pandemic will begin to recede. This can offer us a brief reprieve to consolidate and move forward what has been learned, both with respect to new approaches to delivering
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care (e.g., virtual online services) and new responses to mitigating COVID-19 (e.g., behavioral health providers included as essential health workers). Each domain is very important for our future.

The new administration also holds the opportunity for us to address much unfinished business — consumer direction of care, recovery-oriented care and upstream work on the social and physical determinants of health. These also are very important for our future.

Finally, we sincerely hope that 2021 will be a year characterized by cooperation, collaboration, joint efforts and partnerships. We only can be successful in our mission if we spend as much time working effectively with the broader community as we do working within our own organization. Our future is moving rapidly toward fully integrated care that achieves the outcomes desired by those persons who suffer from behavioral health and intellectual/developmental disability conditions. Much collaboration will be required for us to do this well.

We welcome 2021!

Richard S. Edley, Ph.D., president and CEO, Rehabilitation and Community Providers Association:

In 2020, our lives changed. So have our businesses. A year ago, webcasts were relatively unique; now we all participate in WebEx, Teams, GoTo, Zoom, etc. Conference calls seem somewhat strange and antiquated.

Which leaves us wondering — will we ever go back? Do we really need to go back?

We yearn for face-to-face contact and miss the networking and social opportunities. But do we expect people to again travel distances for meetings?

Further, as to treatment services, we support people forever say, “Well of course ‘face-to-face’ interactions are better than telehealth visits.” But are they? What about consumer satisfaction and increased productivity? What about the data on outcomes and efficacy?

What we have in fact learned from this experience is that we will not be going back. Our lives and business operations have changed forever. Webcasts will be considered typical. Conferences will become hybrid events — capitalizing on some networking opportunities while allowing people to remain at home. In terms of home, offices will never reopen as they had. Telecommuting will be the norm.

So 2020 will be remembered as the year of the pandemic and for the losses we collectively suffered. But when the dust settles, it will also be remembered for how our business operations changed. And perhaps for the better.

Pamela Greenberg, president and CEO, Association for Behavioral Health and Wellness:

As we all know, COVID-19 has not only impacted physical and financial health, it has also had a grave impact on behavioral health. Unfortunately, we anticipate that the rise in individuals experiencing behavioral health problems will remain well after the COVID-19 public health emergency ends.

The increase in the number of people experiencing mental illness and substance use disorders has also brought added attention to these diseases. Behavioral health illnesses, and how to treat them, are being discussed now more than ever.

In 2021, we need to capitalize on the increased attention depression, alcohol and opioid use disorders, suicide and other behavioral illnesses have received. The Association for Behavioral Health and Wellness (ABHW), the national voice for payers that manage behavioral health insurance benefits, plans on doing this by working toward racial equity in the behavioral health system and focusing on our five guiding pillars: increasing access, driving integration, supporting prevention, reducing stigma and advancing evidence-based treatment. In particular, this means we will advocate for policies that improve access to telehealth services, ensure the development of the 988 crisis line, eliminate barriers to medication-assisted treatment, assure implementation of the changes made to 42 CFR Part 2 in the CARES Act and eliminate the Institutions for Mental Disease exclusion.

Carl Clark, M.D., president and CEO, Mental Health Center of Denver:

Due to the pandemic, the Mental Health Center of Denver rapidly shifted to telehealth and evolved to support employees and meet the needs of the people we serve. Many changes are expected to remain post-COVID-19, including the option of telehealth, which many staff and people we serve prefer and has helped reduce our no-show rate by 10%.

Our Innovation Technology Lab will continue its focus on using technology as a “force multiplier” to meet the rise in demand for services. Earlier this year, we introduced our Digital Front Door effort to offer more tools and resources, including a telehealth app, which helps clients connect to care, and an online well-being hub called You@YourBest that provides curated resources and tools for anyone interested in well-being or in search of guidance and information.

Another challenge we will continue to face is the crisis of systemic racism in our country. We strongly believe multiple perspectives foster community, drive innovation and inspire excellence, and we are committed to actively advancing our equity and anti-racism work internally and within our community.

Shawn Coughlin, president and CEO, National Association for Behavioral Healthcare (NABH):

As we welcome a new presidential administration and Congress, the

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NABH will advocate for eliminating burdensome federal regulations, enforcing parity and holding health insurers accountable, and repealing Medicaid’s Institutions for Mental Disease (IMD) exclusion.

While behavioral health care providers continue to treat patients during the COVID-19 pandemic, they must follow a host of reporting and transparency requirements that often strain valuable resources. NABH will work to persuade lawmakers to remove regulations that force providers to shift away from care delivery.

Meanwhile, many of the nation’s managed care organizations have ignored the 2008 parity law and frequently limit coverage to crisis stabilization or short-term, acute-care services because often they use internally developed, nontransparent, medical-necessity criteria that do not reflect generally accepted standards of behavioral health care professional practices. NABH will build on the successful outcome of the Wit v. United Behavioral Health case to make certain that insurers apply criteria that clinical specialty associations have developed.

Finally, Medicaid’s IMD exclusion is an antiquated regulation that has long prevented people with mental health and substance use disorders from receiving necessary care. NABH will continue to advocate for its full repeal.

Joel E. Miller, executive director and CEO, American Mental Health Counselors Association (AMHCA):

The emergence of COVID-19 and the accompanying stay-at-home orders, restrictive hospital visitation policies, social and physical distancing, the abrupt transition to telecommunications and the loss of personal interactions have worsened an already prevalent mental health crisis in the United States.

Compounded by the effects of social isolation, quarantine, critically ill family and friends, death and economic stress, the challenges of mental illness are significantly increasing. Based on surveys by the U.S. Census Bureau and the Centers for Disease Control and Prevention, AMHCA has projected that up to 40% of Americans of all ages and demographic groups have been consistently reporting symptoms of anxiety and depressive disorders since April — with young adults and people of color affected the most.

We also need to acknowledge the mental health and well-being of clinicians, who have been on the front lines battling for nearly 10

NAMI goes virtual, addresses ‘epidemic within the pandemic’

The National Alliance on Mental Illness (NAMI) has, like other organizations, had to contend with a lot regarding COVID-19 and the delivery of its educational programming, according to its CEO. “People fail to realize that we have an epidemic within the pandemic,” Daniel H. Gillison Jr. told MHW. A “ripple of mental health issues” has been exacerbated. Racial trauma and economic issues have created fear and uncertainty, he said.

Much of NAMI’s educational programs are conducted in person. Now it has had to take advantage of new virtual platforms, including Zoom, he said. “We’ve had to pivot and adapt very quickly and demonstrate our resilience,” said Gillison, who is approaching one year as NAMI’s new CEO.

Typically, NAMI has had its volunteers and peers with lived experience with mental illness handle its help line. “We’ve had to pivot and take it virtual,” he said. Gillison said NAMI has seen a 65% to 75% increase in calls to its helpline since the pandemic, adding that the advocacy organization has risen to the challenge in addressing the calls.

One goal next year will be to increase the number of NAMI volunteers and expand its hours, possibly to 8 p.m., he said. Currently, NAMI has 40 volunteers.

NAMI’s annual conference, NAMICOn 2020, also went virtual. The organization successfully dealt with bandwidth challenges. “The upside is we had 12,000 participants with representation from the domestic U.S. and 31 countries,” he said. In the past, participants usually numbered from 1,400 to 1,600, Gillison said.

Prior to COVID-19, the mental health and medical fields provided telehealth, but it had been “spotty,” he said. “We’ve had to look at telemedicine as a solution, but not the total solution,” he said.

Gillison indicated that COVID-19 saw more people being open and discussing mental health. “It helped to create a safe space for many,” he said. “You’ve seen all sectors — private, not-for-profit, entertainment, athletes, political — having a lot more conversation about the importance of mental health. The isolation has created that conversation.”

Another important focus for NAMI in 2021 is more of a connection with youth and young adults, he said. “We recognize that early intervention is critical,” Gillison said. “We’ve seen this year the results of isolation on our young people,” he said.

NAMI is encouraged about its partnership, announced in December 2020, with 13 organizations to create a unified vision for transforming mental health and substance use care in the United States, said Gillison (see MHW, Jan. 4). “Our first order of business is to share a unified vision with the administration, the Hill and across all platforms,” he said.
months the medical sequelae of the COVID-19 pandemic.

Based on the current and projected supply of mental health professionals, the workforce is not prepared to meet the demand for services that we are likely to witness in 2021 and beyond. The incidence of suicide and suicide attempts continues to rise in the United States across all age groups, especially among children and older adults.

COVID-19 has turned the U.S. health care system upside down. The challenges around this pandemic have further exposed disparities and inequities inherent in mental health care.

The social and economic drivers of health, structural racism and inequities are no longer hidden from plain sight and can no longer be ignored. These issues are palpable and at the forefront of the COVID-19 pandemic. People are dying every day and the disparity gaps continue to widen, becoming an abyss for underserved and marginalized populations. Mental health is a vital component of public health and must be addressed in tandem with all other health care related to COVID-19.

An investment in mental health and public health is vital as we prepare for the predicted third wave and aftermath of COVID-19. Without a strong mental health workforce, our efforts may be futile to address negative impacts related to equity, social determinants of health and mental health outcomes. If we remain ill prepared, a “third wave” of COVID-19 may present an unprecedented increase in mental health issues across the United States.

AMHCA strongly believes that it will be critically important, as a starting point, for Congress to pass the Mental Health Access Improvement Act (MHAIA), which would allow clinical mental health counselors and marriage and family therapists (MFTs) to receive provider recognition and reimbursement under the Medicare program. While older adults and disabled Americans suffer because there supposedly is a lack of qualified licensed mental health providers, there is in fact 150,000 such providers ready to address the needs of Medicare beneficiaries who cannot find mental health care in their communities, especially during this mental health and economic calamity. Mental health counselors and MFTs comprise nearly 40% of the mental health workforce. Now is the time to pass the MHAIA to bolster the mental health workforce to deal with the coming surge in demand for services by older Americans. AMHCA — with members of the Medicare Mental Health Workforce Coalition — will be actively fighting for passage of this critically important legislation.

Otherwise, the coronavirus pandemic will have a lasting negative impact on Americans’ mental health.

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“The pandemic and the emergency orders issued in response launched a large-scale, real-time experiment in telehealth,” new Massachusetts House Speaker Ronald Mariano said in comments emailed to MHW. “That experiment was a success, and practitioners, public health officials and patients seemed to agree that telehealth access to behavioral health services was remarkably successful.”

Mental health advocates in the state see several benefits for behavioral health services in the comprehensive legislation, and expect in 2021 to try to leverage the momentum gained last year. Danna Mauch, Ph.D., president and CEO of the Massachusetts Association for Mental Health, told MHW that advocates soon expect to advance legislation that would encompass all of the mental health parity protections recommended by the Kennedy Forum as essential provisions for patients with mental illness.

‘The House proposed permanent payment rate parity with in-person services for behavioral health so that patients can continue to see the benefits of telehealth long after the pandemic is over.’

Ronald Mariano

Summary of legislation

Telehealth access is arguably the cornerstone of the newly adopted legislation’s protections. The legislation seeks to remove any uncertainty about the long-term role of telehealth services in the state’s care delivery system.

The Dec. 22, 2020, legislative fact sheet reads, “Because the lack of certainty around insurance coverage has inhibited wider utilization of and investment in telehealth services by providers, this bill gives providers the assurance they need to make the investments that will expand geographic access, reduce delays in care and improve both pre- and post-care treatment.”

The permanent extension of payment rate parity for behavioral health services delivered through telehealth is particularly noteworthy because under the legislation, payment rate parity for primary care and chronic disease management services delivered through telehealth has been extended for only two years.

“The House proposed permanent payment rate parity with in-person services for behavioral health so that patients can continue to see the benefits of telehealth long after the pandemic is over.’

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