Behavioral Health Vendor Engagement Template

NC BUSINESS COALITION ON HEALTH

National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

HR POLICY ASSOCIATION®

The issues of mental health access and quality have become increasingly recognized as foundational to employer health strategy. Some purchasers have indicated that, while they agree these areas are critical or at least important, they have not been systematically and directly addressing these areas with their vendors. This Vendor Engagement Template (VET) is derivative of the development process of the Path Forward Mental Health Voice of the Purchaser survey conducted earlier this year. These questions are not intended to be comprehensive but rather will supplement questions that might otherwise be included in ongoing vendor management discussions as well as in the vendor selection process. Employers and other plan sponsors are highly encouraged to integrate this tool into ongoing service provider performance assessment and performance improvement plans (or at least until any identified issues are effectively addressed).

Areas of focus:

- Network Access
- Other Access
- Quality of Care Management
- Integration Into Primary Care
- Workplace Mental Health

In addition, in the Appendix, we have provided a case study of one employer's vendor engagement and accountability approach which has resulted in superior access and overall support for its employers. While the facts and circumstances of individual employers may lead to differences in how behavioral health vendors are engaged and held accountable, these tools are designed to help address ongoing issues of concern and emerging improvement opportunities. For additional information, the Path Forward has developed additional resources for employer and plan sponsor use.

Network Access

Systematic Assessment and Management of Gaps in Access for In-network Mental Health Providers

Most health plans and behavioral health (BH) vendors do not systematically and consistently seek to measure or address gaps in access. Efforts that rely on member satisfaction or GeoAccess invariably understate the access issues for new patients seeking care. Many plans have published access standards but do not systematically monitor against those standards or take proactive actions to close identified gaps.

Vendor Questions	Optimal Response
1. How do you systematically assess timely access for in-network BH services? 1.1. Do you have standards for timely access for in-network BH services? 1.1.1. If so, how do often do you monitor against those standards? 1.1.2. What is your current performance against those standards? 1.2. Do you measure the average appointment waiting time; if so, how do you stratify that based on needs? 1.1.3. Emergency/crisis 1.1.4. Non-emergency/non-urgent	Ideally, a health plan or BH vendor systematically assesses provider access through surveys of members seeking services, secret shopper approaches, or review of member complaints. Those reviews should be considered in light of market dynamics including availability of providers in markets as well as within the network itself, availability of other open practices in the geography and in that specialty, provider compensation dynamics, and outreach to recent BH graduates.
2. What percentage of covered mental health services are delivered in-network?	Health plans and BH vendors should be striving to achieve in-network usage comparable to most medical services. Few achieve over 80% in-network usage. It is estimated that 86% of PCPs join commercial networks, compared to approximately 55% of BH/substance use disorder (SUD) providers.

3. When access gaps are identified how do you attempt to close such gaps? 3.1. What is your standard for determining whether there is an access gap? 3.2. How are efforts to close gaps monitored? 3.3. What has been your success rate in closing such gaps?	When access gaps are identified, efforts are made to close these gaps and ensure timely access to necessary care. Success rates vary, but addressing these gaps is prioritized based on network adequacy standards, member feedback, and utilization data. Robust tracking and reporting systems enable monitoring of progress and necessary adjustments.
4. How do you assist members who have difficulty in obtaining a timely appointment? 4.1. How is such assistance obtained? 4.1. What is your success rate in assisting members who request support in obtaining timely appointments?	Members who face challenges in obtaining timely appointments can obtain assistance by reaching out to our customer service team, all of whom are trained in addressing scheduling difficulties and helping navigate the process.
5. Do you assist employers in organizing an access survey by an independent entity?	Where access is not adequately monitored currently, assistance may be provided to employers in organizing an access survey conducted by an independent entity. By leveraging the expertise of an independent entity, comprehensive insights may be gathered to inform network improvements and enhance the overall employee experience.

Behavioral Health Reimbursement

A factor in attracting and retaining mental health providers is competitive reimbursement rates. In many plans, BH reimbursements have not kept up with medical reimbursements and are indefensible in the eyes of the BH provider community. Even when providers participate in networks, they may differentiate access for new patients based on the reimbursement practices of the health plan or BH service provider.

If TPAs offered economic incentives to BH/SUD providers such that more were in-network, then search times, wait times and out-of-network (OON) use would all drop significantly.

Where access issues occur in medical services, special efforts are sometimes made to accommodate patients who are forced to seek care OON.

Members who are forced to see OON providers, may forego care if they cannot afford out-of-pocket costs associated with OON care.

Vendor Questions	Optimal Response
1. How do you monitor the sufficiency of the mental health reimbursement rates to attract and retain network providers for both existing and new patients? Do you measure the speed of provider reimbursement rates?	Ideally, the health plan or BH service provider has a strategy for BH reimbursement that is, (1) successful at attracting and retaining providers, and, (2) commensurate with the skills and training of the providers and the local market dynamics.
2. How are your in-network BH provider reimbursement rates compared to the same codes for in-network medical providers?	In-network BH provider reimbursement rates are designed to be competitive and reflective of industry standards. Offering competitive reimbursement attracts and retains high-quality BH providers, ultimately enhancing the accessibility and quality of mental health services for employee members.
3. Do you provide incentive payments to mental health and substance use providers who meet access and clinical quality metrics?	Incentive payments could be provided to behavioral health providers who meet access and clinical quality metrics. Additionally, studies have shown that another approach that has proved to incentivize providers is matching patients with therapists based on therapists' performance strengths and lived experiences. This approach improves mental health care outcomes, promotes improved access to care, and encourages the delivery of high-quality services.
4. How do you handle copays/co-insurance costs for members who must see ONN providers because they cannot get timely access to in-network providers?	For members seeing ONN providers due to limited access to in-network options, TPAs should evaluate and adjust copays/co-insurance costs to ensure affordable access to necessary care while improving in-network provider availability.

Directory Accuracy

Large directories of providers confirmed with GeoAccess analyses of geographic spread can be deceiving and confounding if those providers are not valid, not accepting new patients, or not prioritizing patients in a particular network. There is evidence that, at times, 80% or more of behavioral health providers listed in a directory may not be available to see new patients, and some of the ones that do agree to see new patients offer untenable wait times to do so. This results in many patients experiencing frustrating searches (4–10+ providers to get a call returned) or simply giving up on seeking treatment. For those that can afford to, many simply seek out-of-network treatment at significant expense and sustain those arrangements over time. This results in inequitable access for employees and their families.

Vendor Questions	Optimal Response
1. How many providers, by specialty, are listed in the directory? 1.1. For those providers, what percentage are estimated to be accepting new patients? 1.2. For those providers, what percentage have submitted 10 or more in-network claims in the past year? 1.3. For those providers, what percentage have submitted two or more in-network claims for a new patient in the past year? 1.4. When there is evidence that a provider is not seeing new patients, what steps do you take related to provider outreach and/or listing in the directory?	Provider specialty breakdowns should be sufficient to assess access to various sub-specialties within the network (e.g., psychiatrists specializing in adolescent BH). A sample breakdown is shown in the case study included in the Appendix. The network should be monitored to ensure sufficient numbers (and availability of) BH/SUD providers by specialty so that the metrics provided will give a more objective measure whether listed providers are actually seeing network patients and particularly new patients. Directories should be regularly updated based on a systematic assessment of current provider availability. Ensuring frequent evaluations and updates to maintain accurate and up-to-date information in directories is imperative for enabling efficient and reliable access to providers.
2. How often are directories updated based on a systematic assessment of current availability? 2.1. How are providers treated in the directory who do not confirm they are taking new patients? 2.2. How are network gaps assessed when the directory update is completed?	TPAs should have a systematic approach to ensure that provider directories accurately reflect providers available to new patients. Where a significant percentage (over 50%) of the listed providers are not accepting new patients, the directory should flag those that are accepting new patients. Network gaps should be evaluated based on those accepting new patients, not on who is listed in the directory.

Other Access

Mental Health Parity

The law requires that all plan sponsors be prepared, within 45 days of receipt of a request from the U.S. Department of labor (DOL), to provide a detailed analysis of non-quantitative treatment limitations (NQTLs) using a multi-step methodology.

It is necessary for the TPA to prepare this analysis because it relates to TPA NQTL policies and procedures developed and managed by the TPA, of which the employer is likely to have little or no knowledge or control.

The DOL has not been satisfied with health plan submissions related to parity compliance. Further DOL guidance is anticipated.

While typical TPA contracts do provide limited indemnification, that indemnification typically does not specifically address parity non-compliance where the plan sponsor is highly dependent on the TPA's efforts to maintain compliance.

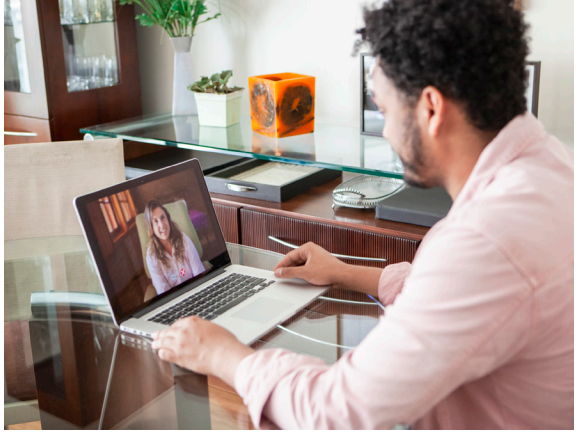
Vendor Questions	Optimal Response
1. Provide a sample report on how you support plan sponsor compliance with mental health parity.	The health plan provides credible parity support consistent with DOL guidance. The health plan agrees to indemnification to the extent that parity violations are uniquely the result of the health plan's practices.
2. Are you willing to provide indemnification for mental health parity compliance?	**Sample indemnification language** MODEL HOLD-HARMLESS LANGUAGE ("MHHL") For Agreements Between Employers Sponsoring Self-Funded Group, Health Plans, and Their Third- Party Administrators

Tele-Behavioral Health

Virtual appointments are an efficiency-boosting way to utilize scarce BH/SUD resources, as they greatly reduce costly no-shows and time away from work.

Matching of the unique needs and circumstances of patients to BH providers has been shown to improve engagement, sustain treatment, and substantially improve outcomes.

People value having a choice among in-office, audio-video, and audio-only treatment modalities. Having a choice increases treatment compliance.



Vendor Questions	Optimal Response
1. Please provide the following your tele-behavioral health services: 1.1. Utilization rates 1.2. How long to get an appointment 1.3. Treatment outcomes	Tele-behavioral services are widely accessible and accessed. Systematic assessment and reassessment are performed to determine treatment effectiveness.
2. To what degree and how do your tele-behavioral health services promote matching of BH clinician or therapist with the needs of the patient based on: 2.1. Severity and urgency of the issue 2.2. Nature of the issue 2.3. Demographics and culture of the patient	Efforts are made to better understand patient needs and match providers to those needs. A recent study demonstrates the benefits of prospectively matching patients to therapists with empirically derived strengths in treating patients' specific concerns.
3. Do you reimburse audio-only and audio-video BH/SUD sessions at the same level as in-person visits?	Ideally, reimbursement does not bias treatment modalities for either the provider or the patient.
4. What provider supports do you offer to help providers overcome any barriers to offering tele-behavioral health?	It's important to support in-network providers by giving them access to a free provider portal for virtual visits. This reduces barriers to HIPAA-compliant technology for virtual audio or audio-video sessions.

Denial Rates

Inappropriate denials can lead to delayed or interrupted treatment, reduced access to necessary care, financial burden, treatment effectiveness, and exacerbation of symptoms. Legacy behavioral health coverage practices sometimes relied on deny and delay tactics. Unnecessary denials and administrative burdens are major contributing factors to providers not participating in networks.

Vendor Questions	Optimal Response
1. How do you ensure denials are clinically justified and sensitive to patient needs? 1.1. How are your mental health denial rates compared to medical denial rates? 1.2. What % of denial rates are reversed? 1.3. Provide a % breakdown of the top 5 reasons for denials and the % of denials they represent? 1.4. Do you provide the nature of denials, and what options are presented to clients when receiving a denial?	To ensure denials are clinically justified and sensitive to patient needs, it is important for health plans to establish robust review processes, engage healthcare professionals in decision-making, and consider the individual patient's unique circumstances and medical requirements. The health plan/TPA should seek to achieve the highest possible rate of denial reversals by thoroughly reviewing appeals, considering additional information, and ensuring compliance with all applicable guidelines. While the specific breakdown of denial reasons may vary over time, currently, some of the top reasons for denials are as follows: ▶ Authorizations — 48% ▶ Provider eligibility — 42% ▶ Code inaccuracies — 42% ▶ Incorrect modifiers — 37% ▶ Failure to meet submission deadlines — 35%

Health Equity

Issues of health equity are exacerbated in mental health. Of particular concern is the expectation of patients that their provider can identify with and appreciate their life experiences. A related concern is the need to develop a trusted relationship between patient and provider.

Many people with lower incomes and from certain ethnically and culturally diverse communities often encounter additional obstacles when seeking mental health treatment. A study found that biases within the provider community can create even greater barriers to getting appointments.

Stigma surrounding mental health may be even stronger in certain communities and further complicate willingness to seek care. This concern is further exacerbated if their experience in seeking or getting care does not meet their needs.

Only 5% to 7% of mental health care providers in the US are racial or ethnic minorities, so the need for cultural awareness in the broader provider community is critical.

Vendor Questions	Optimal Response
1. Do you evaluate engagement and outcomes of behavioral health services for ethnically and culturally diverse communities? 1.1. If so, what have been your observations in this evaluation? 1.2 How, if at all, do you personalize BH services to better meet the needs of ethnically and culturally diverse communities?	Health plans and BH service providers strive to offer and communicate diversity within their provider networks and help individuals to better match providers to their unique needs and circumstances. Health plans and BH service providers should continually work to expand and enhance our network, ensuring access to quality healthcare for all our members while respecting and valuing the diverse backgrounds and identities of each person.
2. Please provide a breakdown of your network providers? (e.g., LGBTQ+, African American, Black, Asian, Haitian Creole, Hispanic...) 2.1. Which demographic and specialty background on providers do you collect in the credentialing process? 2.2. Which demographic and specialty background of providers do you include in directories? 2.3. Do you provide pictures of your providers in the directories? 2.4. How do you consider matching providers who are best suited to meet the specific needs and experiences of underserved populations?	To enhance the overall healthcare experience and ensure that members from traditionally underserved populations have access to providers who can best meet their specific needs and experiences, comprehensive directories aim to include provider pictures. Additionally, factors considered for matching providers to underserved populations include cultural competency, language proficiency, and specialized expertise, promoting equitable and inclusive care.

Quality of Care Management

Standardized Measurements and Evaluation

Studies show that consistent use of validated symptom measurement tools improves treatment outcomes by 20%–60% and generates a nearly 75% difference in remission rates between patients receiving measurement-based care (MBC) and those receiving usual care.

Despite the clear evidence of value, the adoption of MBC as a standard of care has been slow and inconsistent.

While some strides have been made recently, accreditation agencies have asked for explicit support from TPAs to make MBC a universal requirement.

Vendor Questions	Optimal Response
1. How do you encourage members to be systematically screened for depression, anxiety, and SUD?	TPAs should be encouraging the broad use of MBC and evaluating the impact of their policies (e.g., medication management) on patient experience and outcomes.
2. How do you promote and reward the use of standardized measurements for behavioral health specialists? 2.1. Which standardized measurements qualify?	To encourage systematic screenings, recognized standardized measurements, such as PHQ-9 and GAD-7, can be incentivized through performance-based rewards, as well as regular collaboration with network providers to promote routine screenings during primary care visits.
3. How do you evaluate the appropriateness of your medication management approach (e.g., formulary, step edits...) for mental health conditions such as depression? 3.1. Do you evaluate patient experience and outcomes? If so, what has been your experience?	Regular assessment of the medication management approach for mental health conditions like depression should align with evidence-based practices (this includes regular review of formulary, step edits, and other medication management strategies to ensure they align with the latest clinical guidelines). Patient experience and outcomes should be continuously evaluated through feedback and outcome assessments, helping to optimize strategies for effective and appropriate care.

Integration into Primary Care

Supporting and Promoting Behavioral Health Integration (BHI) into Primary Care

To implement strategies for comprehensive patient care strategies to enhance patient care the health plan should implement the following approaches:

- **Systematic Initial Assessment:** Encourage providers to conduct thorough and systematic initial assessments to identify patients' behavioral health needs accurately.
- **Brief Intervention and Treatment:** Include early intervention and brief treatment approaches for mild to moderate behavioral health concerns, within BHI strategies.
- **Triage to Appropriate Levels of Care:** Facilitate the seamless triage of patients to the most appropriate levels of care based on their specific needs.
- **Reassessment for Outcomes:** Regularly assess patient progress and outcomes to adjust treatment plans as necessary.
- **Integration with Other Care and Support Provided through Primary Care Provider (Whole Person Health):** Actively promote collaboration/communication between BH providers and primary care, facilitating the integration of clinical data and supporting a whole person health approach.

The Collaborative Care Model (CoCM) is an integrated behavioral healthcare model with extensive research demonstrating its effectiveness, with more than 80 randomized control studies showing:

- Improved BH/SUD clinical outcomes.
- Reduced total healthcare costs.
- Increased provider and patient satisfaction.

CoCM is most frequently provided in primary care and requires team-based care including consults

in the absence of the patient. Members are not expecting multiple OOP expenses in primary care, especially for wellness visits. OOP costs for each CoCM encounter are an economic disincentive for members to accept CoCM treatment.

Many health plans have had limited BHI investments in a few large primary care practices to integrate behavioral health. Most primary care practices are small, particularly in remote and rural communities.

Vendor Questions	Optimal Response
1. How do you financially support, promote, and incentivize BHI into primary care? (e.g., CoCM) 1.1. Do you waive "out-of-pocket" CoCM expenses? 1.2. Do you impose any limits on use of code 99494? 1.3. Do you provide training for primary care providers on how to access in-network BH specialists? 1.4. What efforts have you taken to promote virtual health integration into all practice including small practices?	The health plan should prioritize the integration of virtual health services into all practices, offering training to access in-network BH specialists. Health plans should waive members' expenses for CoCM for both fully funded and self-funded plans. The 99494 is a billing code used for short follow-up visits for a member already enrolled in CoCM. Some TPAs limit the frequency of billing for this code, e.g., once per month. This can be a disincentive for providers to provide COCM, limiting care for a member in distress or crisis where more frequent care is necessary and potentially lead to an hospital visit or admission. Health plans should not impose limits on the use of code 99494 and take active steps to support, incent and promote virtual BHI for primary care practices where co-location is not likely or feasible. Where co-location is not practical, there are successful virtual models of BHI that can be scaled much more efficiently and applied more broadly (e.g., Concert Health, Mindoula Health) which can be promoted and supported.
2. Do you promote and reward systemic behavioral health measurement for primary care providers? (PHQ9, GAD-9)	Health plans should reward behavioral health measurements, such as PHQ-9 and GAD-7, through performance-based rewards, as well as regular collaboration with network providers to promote routine screenings during primary care visits.
3. If you are promoting other BHI strategies beyond CoCM, how do you incorporate and promote the following into those BHI strategies? 3.1. Systematic initial assessment 3.2. Brief intervention and treatment 3.3. Triage to appropriate levels of care 3.4. Reassessment for outcomes 3.5. Integration (including clinical data) with primary care	Some health plans have promoted alternative models of BHI (other than CoCM). It is important that those models have a similar commitment to core expectations of BHI. Access to BH specialists can be a major concern for primary care considering and implementing BHI. Existing referral relationships may not exist and may need to be promoted.

Tracking Successful Integration of Behavioral Health into Primary Care

By tracking the integration process, healthcare systems can assess the impact of integrated care models on patient health outcomes, satisfaction, and overall wellbeing. Integrated behavioral health provides enhanced coordination and continuity of care. Integrated care has the potential to be cost-effective by reducing unnecessary referrals, emergency department visits, and hospitalizations. Monitoring outcomes allows healthcare systems to identify areas for improvement, refine care processes, and implement evidence-based practices to optimize patient care.

Vendor Questions	Optimal Response
1. Do you track which primary care practices have implemented a BHI model? 1.1. If so, how do you define BHI for this purpose? (e.g., CoCM, Accredited practices) 1.2. If so, are these primary care practices rewarded for BHI? 1.3. Have you tracked experience under these practices?	The health plan is monitoring BHI implementation, rewarding primary care practices with BHI and helping promote primary care practices that have done so.
2. Do you have a notation in the directory for primary care practices that have BHI? 2.1. If not, are you able to provide such a notation if requested?	To facilitate easy identification, health plans should have a specific notation in the directory that highlights primary care practices that have successfully integrated behavioral health services. This notation allows members to easily access comprehensive care that addresses physical and mental health needs within a single practice, promoting a holistic approach to healthcare.

Workplace Mental Health

Engagement and Program Enhancement for Workplace Mental Health

Mental health, a significant healthcare expense, affects productivity, presenteeism, worker effectiveness, interrelationships, short- and long-term disability, and overall workplace environments.

Employers have offered a myriad of programs and support to address and improve workforce mental health. Engagement in programs has been uneven, although efforts to mitigate stigma have been effective in improving engagement and normalizing discussions on mental health.

Supervisors play a central role in in fostering a mentally healthy work environment (avoiding burnout or toxic work environment) and managing and supporting employees who are dealing with mental health issues for themselves or their families.

Analysis by NSC and NORC at the University of Chicago reveals organizations that support mental health see a return of $4 for every dollar invested.

Vendor Questions	Optimal Response
1. For each behavioral service offered, how do you evaluate and report on engagement with those services? 1.1. How do you define and measure engagement for each service provided? 1.2. How have such programs been adapted to diverse workforces and hybrid work environments?	BH service providers should provide comprehensive and evidence-based support across the spectrum of needs of the employer.
2. What programs do you provide to improve BH awareness and improve stigma? 2.1. Please describe engagement rates and evidence of impact on program utilization.	Ideally those programs are adaptable to the nature and culture of the organization and have a track record of engagement and impact.
3. How are your BH programs integrated with other health and wellbeing programs offered to support whole person health? 3.1. Please describe data and process for each.	Mental health programs should be integrated with other wellbeing programs and have systematic feedback loops to the organization where toxic environmental factors are emerging.

4. Do you offer supervisor training for mental issues? 4.1. If so, what topics are addressed in such training? 4.2. How is the impact of such training assessed and what have been your results?	Health plans should offer supervisor training for mental health issues. This training equips supervisors with the knowledge and skills to recognize and appropriately address behavioral health concerns members.
5. Do you provide reports containing an integrated picture of employee population behavioral health, medical conditions, and risk factors?	Health plans/TPAs should work with employer members to provide comprehensive reports that offer an integrated picture of the employee population's behavioral health, medical conditions, and risk factors. Ideally, reports are designed to provide valuable insights into the overall health and wellbeing of employees and inform decisions for implementing targeted wellness initiatives and organizational improvement that address the specific needs of employees and their families. Such reports ideally also help identify differences in the needs and engagement of identified subpopulations for health equity purposes.

Appendix

Employer Case Study

State of Tennessee

Here4TN

"State of Tennessee RFP and Contract is in public domain"
https://www.tn.gov/partnersforhealth/contracts.html

State of Tennessee Approach

- Dedicated call center team through Optum
  - First call provider search started promoting in 2021, increased from 1,730 in 2021 to 2,395 in 2022.
  - Staffed by licensed behavioral health professionals (master's level or higher), preferably Certified Employee Assistance Professionals.
  - Available 24/7.
  - Unlimited consultations.
  - Risk screenings for substance use and suicide with every call.
  - Risk assessment to determine need:
    - Impromptu debrief of the situation
    - Can dispatch crisis services if needed (emergency department, Inpatient facility)
    - Routine visits can be done in person or virtual
- Directories are updated every 90 days
  - Providers must attest to their listing in Optum's directory or else they will be removed from the directory.
- Optum always takes the member type of need as priority
  - Preferences such as gender, age expertise, etc., taken into consideration
  - If those preferences limit the team's ability to find a provider that has openings, they will adjust in order to be able to provide the member with an appointment.
- All data is confidential, not shared, or released.

State of Tennessee Access Outcomes

- In-network behavioral health care utilization in 2022 was 93% with an increase in overall utilization of 7.3%.
- *Q1 2023 had 99% compliance with access standards of:*
  - Emergency/crisis within 4 hours
  - Urgent care within 24 hours
  - Routine within 72 hours
- 79.4% EAP resolution rate in 5 visits or less without the need to move to behavioral health.

State of Tennessee GeoAccess standards

Provider Network Accessibility

Provider access requirements reporting and guarantee:

- 95% of all state, local education, and local government plan enrolled members residing in Tennessee shall have the access standard indicated.
- Should there be a deficiency in the network due to the unavailability of licensed providers in a specific area, the contractor shall provide sufficient documentation with their access analysis report to request reconsideration of the access standard for that provider type for the reporting period in question.

Provider Type	Access Standard (Urban, Suburban, and Rural)
Psychiatrists and Advanced Practice Psychiatric Nurses	2 providers within 10 miles 2 providers within 15 miles 2 providers within 30 miles
Psychologists	2 providers within 10 miles 2 providers within 15 miles 2 providers within 30 miles
Child/Adolescent Providers	2 providers within 10 miles 2 providers within 15 miles 2 providers within 30 miles
All other Master's Level Providers	2 providers within 10 miles 2 providers within 15 miles 2 providers within 30 miles
Medication Assisted Treatment Providers	1 provider within 10 miles 1 provider within 15 miles 1 provider within 30 miles
Inpatient Acute Care Facilities	1 facility within 20 miles 1 facility within 30 miles 1 facility within 40 miles
Intermediate Care Facilities (Residential and Partial)	1 facility within 20 miles 1 facility within 30 miles 1 facility within 40 miles
Intensive Outpatient Facilities	1 facility within 20 miles 1 facility within 30 miles 1 facility within 40 miles

10130 Mallard Creek Rd, Suite 300 · Charlotte, NC 28262
704-944-3135 · ncbch.net
www.linkedin.com/company/north-carolina-business-coalition-on-health

NCBCH
NC BUSINESS COALITION ON HEALTH

National Alliance of Healthcare Purchaser Coalitions
1015 18th Street, NW, Suite 705
Washington, DC 20036
(202) 775-9300 (phone)
(202) 775-1569 (fax)

National Alliance
of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

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