PANEL 2 – HEALTH PLAN ELIGIBILITY, BENEFITS INQUIRY & RESPONSE (PART 1)

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For decades, the challenge of addressing mental health has been profound. In fact, it doesn't take too deep a read into history to see that our society and our healthcare system has not truly understood mental health and what to do with it. Consider how in 1963, when President Kennedy signed the first piece of federal legislation on mental health that established community mental health centers, there became a need to define what a mental health benefit was and what was not. This struggle to bring these often inadequate benefits to a place where they could help those who needed help the most was a battle fought for decades until the passage of the Affordable Care Act, which included mental health parity.

However, much of what we know about mental health has drastically changed in recent years. We have learned that treating people for mental health is much more effective when done so in the community; that addressing the whole of health is far more effective than just the part. That separating out the mind and body is an impossible reality due to their interconnection and interdependency. Yet our systems in healthcare, no matter how much they have changed, have struggled reconciling these facts. To be clear, we perpetuate this false dichotomy of mind and our body every day through clinical care delivery, financing of healthcare, and our training and education programs.

Today, I offer up insight and testimony to the challenge of looking at mental health through a different lens. It is simply impossible to consider Health Plan Eligibility, Benefits Inquiry & Response without first having a grasp on the state of mental health in healthcare and where the field is going.

For decades research has shown how more mental health is seen in non-mental health settings than anywhere else.[1-4] In fact, if one breaks down these data, it is clear, primary care has become the de facto mental health system for the vast majority of the United States.[3] One cannot have a conversation on mental health eligibility without first acknowledging that many individuals with a mental health condition who show up in primary care either a) do not get help; or b) do not follow up on their referral.

Integrating mental health providers into primary care holds the promise that patients will have more instantaneous access to a mental health provider, which is greatly needed.[5,6] Consider for example that two-thirds of primary care physicians surveyed (n=6600) indicated they could not get access to specialty mental health services for their patients.[7] This survey was in response to the 2008 passage of mental health parity, which was meant to help patients better receive mental health services and have benefits that were at parity with medical benefits. The problem, as is highlighted through this study, is that most primary care providers do not have the ability to connect to the specialty mental health system in ways that can help their patients in the moment their patients need it most even if the benefit for the patient is indeed there.[7]

To offer another example, consider how patients often do not initiate treatment or complete treatment when referred from primary care for mental health. In a recent study, researchers found that families, when offered mental health interventions onsite in pediatric practices for children and adolescents, were nearly seven times more likely to complete care than when referred to a specialty mental health setting. This rigorously designed study found that of the 321 children involved in the study, 160 were randomized to receive mental health treatment in a primary care provider’s office and 161 were randomized to receive treatment in a specialty mental health setting. The families offered integrated mental health in primary care initiated care 99.4 percent of the time and 76.6 percent fully completed treatment. Compare these data to the 54.2 percent who initiated care (e.g. showed up to their referral) in a specialty mental health setting with only an 11.6 percent completion rate.[8]

An integrated care model approach which has been shown to be more effective, and as I just highlighted, efficient. This scenario may often lead the primary care clinician to a place where they may be making the eligibility inquiry on behalf of their clinic or an integrated delivery system, or even the onsite mental health clinician. As some efforts are starting to show, new payment models will also impact the way we think about Health Plan Eligibility, Benefits Inquiry & Response. For example, if a primary care practice is under a capitated arrangement for their patients, which includes patients with mental health diagnoses, they may want to treat that patient in their practice rather than refer out. In this scenario, the benefit may not even be enacted for the patient as their mental health service is just another part of the primary care delivery. Alternative payment methodologies and new risk contracts may mean something very different for mental Health Plan Eligibility, Benefits Inquiry & Response for mental health.

I encourage the committee to see such critically important issues like Health Plan Eligibility, Benefits Inquiry & Response in the context of a much broader view of mental health in healthcare. Medical providers, like primary care physicians, often have to decide what to do with patients who have mental health needs daily. As data suggest, even if a patient has the benefit, they are not likely to show up for their mental health referral even if the practice is told there is a benefit there.[8,9]

We may consider moving away from the notion that “one size fits all” for mental health, and reflect that in some cases, what our patients are eligible for is a service they do not want to use. We should also consider how new payment methodologies that better support the inclusion of mental health services in primary care will change the need to know who is eligible for what. The entire notion that mental health will predominately be a separate service is changing in deference to a more population based model of care that allows for more timely access at the point of identification, often in primary care. These emerging models will change the way we think about eligibility and in many cases, change the entire structure of a benefit. Since the majority of the research has been done on the clinical aspects of these

integrated approaches to mental health, more study may be needed to understand the complex implications of integrating mental health more seamlessly into a benefits design. Future operating rules and standards may wish to assess the differences in eligibility and benefits inquiry when mental health is provided instantly onsite rather than through a traditional referral mechanisms to a different provider and system.

For example, on might compare healthcare clinics and systems who have mental health services as a part of their overall delivery model (e.g. not carved out or a separate line of service) and how those benefits are designed and eligibility assessed (if even necessary) to those clinics who have traditionally treated mental health as its own separate entity.

To be clear, in many cases the integration of mental health into primary care will not replace the specialty mental health system and function, but in fact complement it in several different ways (e.g. more appropriate referrals enhancing operational efficiency on the specialty end). For those patients who do need more specialty mental health services, the traditional aspects of Health Plan Eligibility, Benefits Inquiry & Response are indeed and necessary. However, the direction in which the vast majority of the country is going pertains more to instantaneous access to mental health, in primary care, whereby the patient can have a more seamless comprehensive approach to their health.[10,11] This integrated care approach is growing and I encourage the committee to consider how this will impact Health Plan Eligibility, Benefits Inquiry & Response for mental health.

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