

## PANEL 3 – PRIOR AUTHORIZATION

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When patients are in crises, having to go through a prior authorization process can be daunting. In some case, like that with mental health, the process can also be terrifying due to fears, concerns, trust and in some cases, stigma. In a society that has prioritized instantaneous access for almost everything, how satisfying is the patient experience when one has to wait to see your provider despite the prior authorization happening immediately through electronic means? I testify today in response to the problem often faced by people in need as it relates to their mental health and prior authorization.

The mental health world, like the broader healthcare world, has often been one that has been overtly fragmented.<sup>1</sup> There are outpatient services, inpatient services, services for substance use, and psychiatric emergency services. Sometimes even these different parts of the delivery system do not have connection or the ability to communicate with one another. Depending on one's need, there is likely a place to go to get help. The challenge for most people is that when they are finally at a place to open up and talk about a concern they have, mental health or not, the mere act of disclosing can be a hard one. The additional challenge is that oftentimes when people open up to talk about these issues it is to their primary care provider.<sup>2,3</sup>

Due to historical underpinnings, we have developed a one size fits all approach to mental health.<sup>4,5</sup>

Patients, when identified with a mental health issue are often referred from the setting in which they are identified. In most cases, this requires prior authorization for that service; however, there are two issues that arise when this occurs:

- 1) Patients do not show up for their referral; and,
- 2) The disclosure of this issue to the system may be more than the patient wants (e.g. due to concerns about stigma, job security)

Even if these two issues were not true, receiving prior authorization and then coordinating care remains problematic between mental health and primary care. The entire premise of prior authorization is about making sure that a patient is eligible and connected for their next service. Data suggest that we cannot feasibly rely on enhancing coordination to improve mental health referrals and communication in our communities even if the patient is indeed approved for the service. Take for example a survey done on some of the best primary care practices in the country; those who were certified as NCQA patient-centered medical homes (PCMH). Researchers found that despite becoming PCMH, practices still did not have the adequate mechanisms to coordinate, communicate, and track referrals made to specialty mental health.<sup>6,7</sup> This begs the question – what role does prior authorization have when mental health may move to the setting where the patients are being identified most often? Health plans should expect to receive electronic prior authorizations for mental health services from provider organizations where the requester is providing both primary care and mental health services, in some cases onsite together.

What happens when no prior authorization is needed because the care is offered right then and there in the moment the patient needs it most? Prior authorization becomes somewhat of an artifact of a past time when two separate systems united to address health. However, in the case of prior authorization, it is important to differentiate between mental health services that may be onsite compared to those that are truly integrated. As more non mental health settings, like primary care, become responsible for assuming much of what happens with mental health, the need to differentiate full access to mental health onsite vs. a referral model to specialty mental health onsite becomes important and necessary.

When primary care has mental health onsite, integrated onto the team, the need for prior authorization may indeed go away. In the era of payment reform, there may be more alternative payment models that allow for primary care to go at risk for certain mental health conditions meaning those historical benefits for mental health may look differently when integrated into an overall health or medical benefit. If the onsite approach consists of a separate mental health service line that has its own rules, finances, and operating procedures independent of the primary care team, then prior authorization may be necessary to assure this separate service and provider will be covered. One could think of this approach as replicating what is often seen on the outside of primary care but inside with closer proximity. In essence, there will emerge two dominant approaches to mental health in primary care and the prior authorization need and function will vary based upon which approach is adopted.

I encourage the committee to consider the implications of prior authorization around mental health in an era of payment reform and clinical integration. In service to enhanced operational efficiency, there may be scenarios to be studied that address the role of prior authorization around mental health when payment reform and benefits packages have mental health as a more seamless part of the care delivery rather than a distinct and separate service.

As research has shown, good primary care addresses mental health.<sup>8</sup> In many cases, differentiating mental health as a specialty vs. mental health as part of primary care and serving more of a generalist function may be useful in understanding the role of prior authorization. Since we cannot separate the latter, perhaps there are some cases when having a separate system to address mental health works against the best interest and needs of the patient (e.g. carving out all mental health benefits and services).

There are two assumptions, however, that must be mentioned here to fully understand the promise of integration:

- 1) The primary care practices has an onsite mental health provider, on the team, that can address whatever those mental health needs are in primary care; and,
- 2) The patient does indeed want treatment for their mental health in primary care.

As more accountability is assigned to communities at both a local and regional level, the need to assign attribution and track patients will become more important. So too will the notion of prior authorization and what role it will play as systems become more aligned and seamless.

My ask for the committee is to consider the role of prior authorization with patients who have mental health needs when the mental health delivery may not be in a different setting from which it is identified. There may be unique considerations when seeing mental health as part of a primary care visit compared to stand alone mental health services that occur subsequent to being identified in primary care that can be addressed through operating rules. Thank you.

## References

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