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Health Plans and Mental Health:

How Payers Can Better Engage With the Burgeoning Behavioral Health Industry

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EXPERTISE & SERVICES: Health Plans

The Mental Health industry and its influential recognition within Population Health has grown significantly in recent years. Health Plans specifically are playing a more integral role than ever before, with many Payers utilizing Behavioral Health as a key component to their health equity and value-based strategies. The reason for this change is two-fold: First, due to COVID-19, rising substance abuse, and a variety of socio-economic factors, American patient populations are in greater need of behavioral health supports. In our recent Mental Health spotlight, we discuss the industry's evolution, as well as the heightened patient demand being experienced across multiple sectors. Second, Health Plans are increasingly acting on the fact that preventative mental health treatment leads to a reduction in overall spend, as proactive community-based solutions improve population health outcomes.[1,2]

The question left for Payers: How do they navigate an ever-expanding behavioral health industry, that has a glut of new entrants, shifting policy trends, and a host of therapeutic advancements, in order to optimize their mental health model of care? In this article we'll review 5 top industry trends in mental health, including the opportunities and challenges they represent to Health Plans.

1 Surging Medicaid

Boon: **Strong demand, new funding sources**
Caution: **Behavioral Health VBC often kneecapped by member churn**

Medicaid enrollment has ballooned in recent years, with it now representing more than 90 Million Americans. Most notably to the mental health space, Medicaid is the single largest Payer of behavioral health services, despite commercial insurers nearly doubling their size in total enrollment.[3] Medicaid reimburses an outsized portion of psychiatric encounters due to several reasons, including influential social determinants of health (SDOH) factors that disproportionally impact lower income patients. Representative of this, Medicaid beneficiaries have consistently demonstrated a higher prevalence of behavioral health disorders, making mental health care models an integral component to a Payers' Medicaid strategy.[4]

Several industry developments have accompanied this unprecedented growth in the Medicaid sector. Most notably, the federal government recently doubled down on its commitment to Certified Community Behavioral Health Clinics (CCBHCs) by funding their nationwide expansion.[5] In addition to new federal resources, managed Medicaid organizations are similarly leaning into the mental health needs of their beneficiaries, as a majority of privatized Medicaid Payers have expanded behavioral health coverage in recent years.[6] Nevertheless, supporting mental health within Medicaid populations remains a challenge for a variety of reasons, including structural limitations associated with value-based care. Value-Based Reimbursement is challenging at baseline, and the care journey to realizing value through mental health is longer than other medical specialties, which further complicates the framework for value-based reimbursement. In addition, Medicaid Payers experience a higher degree of beneficiary "churn", as members bounce on and off Medicaid plans due to changes in employment status, shifts in qualification policy, as well as various other life events which can interrupt their eligibility.[7] This beneficiary turnover limits Payers from forming personalized relationships that are geared around maximizing long term outcomes, a necessity in effective VBC contracting.

2 Flexible Medicare

Boon: Increased benefit flexibility and strong future demand forecast
Caution: Social restraints exacerbate baseline mental health issues

Medicare beneficiaries are high utilizers of the mental health space. Patients older than 65 disproportionately experience preexisting conditions which exacerbate behavioral health issues. Recent studies have demonstrated that over one-third of older adults experience loneliness, a determinant that is closely related to an increased risk for various chronic conditions, including heart disease and dementia.[8] In addition, its estimated that 24% of Medicare beneficiaries have no one living nearby to support them, and 27% don't know where they can go to meet new people.[9] Once more, the behavioral need is expected to grow within Medicare, as the total industry is expected to grow by over 15% within the next 10 years.[10]

Encouragingly, the Medicare industry has experienced a variety of recent developments geared towards enabling Health Plans to more creatively support their member's mental health needs. The reinterpretation of Medicare's long standing uniformity clause allows Health Plans to funnel personalized benefits to members experiencing chronic conditions. In addition, Medicare Advantage supplemental benefits have become increasingly flexible, and are being deployed in new, innovative ways, with many targeting issues related to social isolation. Finally, recent reforms in Fee-for-Service Medicare have also emphasized behavioral health supports, with the new Medicare Shared Savings Program (MSSP) allowing for expanded behavioral health coverage, including opioid treatment, as well as payment parity for clinical psychologists and Licensed Clinical Social Workers (LCSW).[11]

3 Alternative Therapies

Boon: Recent research demonstrates potential of alternate therapies
Caution: Many therapies still face significant regulatory barriers

Once stigmatized as a taboo corner of medicine, alternative therapies are becoming increasingly accepted and recognized for their clinical capabilities. Top universities are leading the charge in demonstrating their medicinal merits, as Johns Hopkins and the University of Pennsylvania recently published studies demonstrating how they can be leveraged to improve outcomes for patients with select comorbidities.[12,13] In addition to clinical advancements, alternative therapies have recently experienced a number of regulatory successes as well. A growing list of state legislatures have legalized Psilocybin, with Oregon leading the way and New Hampshire and California looking at similar measures. There have also been Federal developments in recent years, as the FDA approved a ketamine medication for adults with treatment-resistant depression.[14] Most recently, the FDA issued a first-of-its-kind guidance on clinical trials for psychedelic drugs, marking a shift in policy and signifying further support of the greater potential for psychedelic therapies.[15]

These developments represent an interesting opportunity for Payers, as many of these medicines are designed for high acuity patients who have been challenging to support using traditional methods. Alternative medicines, such as Ketamine, LSD, MDMA, and Psilocybin have all shown promise in treating complex mental health diagnoses, such as PTSD, AUD, and Depression.[16] In addition, the opportunities associated with these therapeutics extends to less acute diagnoses, including eating disorders and palliative care needs. While the outlook for the full gamut of alternate therapies is unknown, what's clear is they have considerable clinical potential, and with additional research and regulation, they represent a viable resource for Payers looking to better support their member's behavioral health needs.

4 Social Determinants

Boon: Increased awareness of SDOH importance across healthcare industry
Caution: Data gaps and rigidity of traditional insurance models limits capabilities

Social determinants of health (SDOH) have long been an influential driver of health outcomes, as approximately one-half of all health outcomes are driven by SDOH.[17] This is a staggering statistic, especially in considering the amount of time, energy, and attention afforded to other healthcare components, such as access and affordability. In addition to their consequential nature, social determinants represent a unique challenge for Payers, as they are broad in scope, and encompass aspects of a member's care-journey that fall outside the bounds of the traditional insurance model. In addition, the SDOH factors impacting members are often not claims-based, and as a result, can be challenging to track and measure. This lack of data integrity often limits Health Plans' ability to identify at-risk members, making it even more challenging to support members and prevent acute medical episodes.

In spite of these challenges, the Payer community has increasingly recognized the opportunity SDOH represents in terms of improving mental health. Many Health Plans are working with providers to update their encounter processes to include questions around social determinants, including housing, food insecurity, and employment. In addition, Payers are more frequently adopting a wholistic, collaborative approach to SDOH, by emphasizing the importance of partnerships with Community Based Organizations. These partnerships often demonstrate a specific commitment to health equity, as marginalized populations are often disproportionately impacted by negative SDOH factors, resulting in a correlated impact on their mental health.

5 Digital Platforms

Boon: Significant growth in new tools and outside investment
Caution: Digital solutions have inherent limitations (shiny object syndrome)

The digital mental health space, as enabled by technological advancements and supercharged by COVID, has undergone unprecedented growth in recent years. In 2021 alone, an estimated $5.1B was raised by mental health tech startups, nearly twice as many as the $2.7B raised in 2020.[18] This growth has helped advance health equity by improving access to care, as digital solutions bridge this gap by reducing the friction associated with geographic and transportation-specific limitations. In addition, digital platforms help improve care personalization, by enabling greater flexibility when Payers facilitate provider-patient connections. This alignment of improved convenience (access) and experience (personalization) is especially powerful, as it can help drive plan-of-care adherence, a key metric in positive behavioral health outcomes.

At the same time, digital platforms are far from a panacea, and rather a new resource with inherent limitations. One drawback of digital solutions is the way many focus on the wellness side of mental health and are subclinical; meaning patients with higher acuities (or specific diagnoses such as depression) cannot utilize them for treatment. In addition, many of the new-to-market digital platforms utilize a business to consumer business model, which effectively circumvents the patient's insurance company. Under this structure, patients pay out of pocket, a challenge for many and especially individuals with lower incomes. Additionally troubling, the direct-to-consumer clinical encounter can isolate the patient's health insurer, leaving Payers in the dark regarding clinical issues critical to their beneficiary's health status.

SUMMARY

The mental health industry is undoubtedly at an inflection point. The past several years have seen technological advancements, legislative breakthroughs, as well as the easing of historic and pernicious stigmas. Health Plans sit at the epicenter of this change and have the opportunity, as well as the responsibility, to participate more meaningfully than before.

In doing so, discernment will be critical, as the go-to-market strategy will need to be designed with the patient in mind. Beneficiaries with different demographics, conditions, and socio-economic backgrounds will have different behavioral health needs, and as we know, Health Plans are the primary arbiter of how plans of care are administered. There is tremendous value in supporting mental health, both in terms of improving population health outcomes, and reducing unnecessary medical utilization. Ultimately, the Health Plans that support their beneficiaries' behavioral health needs most effectively will be best positioned to deliver on the triple aim.

At Vynamic, we offer a range of services through an integrated approach to adopting new initiatives. These include product design, value-based contracting advisory, digital transformation, and clinical operations change management. Contact us to find out how Vynamic can support your organization's strategic imperatives related to Behavioral Health, as we believe there is a better way to healthcare.

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END NOTES

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