



## PUBLIC POLICY STATEMENT

# ACCESS TO MENTAL HEALTH TREATMENT

### BACKGROUND

The Public Policy Committee of the Mental Health Association in New Jersey has identified access to treatment as a primary policy/advocacy concern. There has been anecdotal information that people seeking mental health services have been having increasing difficulty linking in a timely fashion with professionals in both the public and the private mental health systems. It has also been reported that there is an increase in adults and children in hospital screening facilities, having been unable to access treatment elsewhere at an earlier point of distress. The committee has identified aspects of this issue and decided to pursue a central problem area that affects the availability of treatment in both private and public sectors.

### PROBLEM

There is a quiet revolution going on in mental health care in New Jersey that is seriously affecting access to treatment. The private behavioral health networks, usually employed by insurance companies, are unable to provide services needed by citizens requesting treatment. While there is the outward appearance that managed healthcare organizations have adequate numbers of professionals in their networks, anecdotal evidence indicates that private practitioners have been exiting managed care networks in large numbers. As a result, while their names may still remain as providers of a particular company, when contacted, they are unavailable to provide for treatment.

Because of the networks' focus on limiting care - and their habit of dealing with mental health professionals as a workforce to be managed and controlled, professionals, in response to the volumes of paper work and low reimbursement rates, are leaving the system. The insurance industry is destroying the networks of mental health practitioners.

As the managed healthcare organizations loses more and more private practitioners, people who may have been able to afford private care with their insurance coverage find themselves unable to find clinicians who are part of their network. They have three options: 1) pay for therapy out of pocket, 2) turn to the public sector of mental health centers for treatment, or 3) do without.

We project that the traditional "dual system of care" that split those with insurance and those without into the private and the public mental health systems is shifting in another direction. While still being a dual system, the "haves" will increasingly be those who can afford to pay privately for care, totally. The "have-nots" will still be the poor, but will increasingly be the middle-class who cannot afford to pay out of pocket and will find it difficult to be served by a public system that is overloaded and under-funded.

Many of New Jersey's mental health consumers who are ineligible for public insurance and do not have sufficient private insurance, cannot and do not access treatment until they face an emergency, when they are very sick and their symptoms are impossible to manage. Instead of receiving prevention services and/or

treatment in a timely fashion, they land in homeless shelters, screening centers, emergency rooms and hospitals or, unnecessarily, in other systems: welfare, criminal and juvenile justice and child welfare.

### **POSITION:**

It is the Mental Health Association in New Jersey's position that people who have behavioral healthcare insurance coverage under managed care must have access to the care for which they subscribe and that an adequate number of providers are available to those seeking care. It is the responsibility of the managed care providers and the state departments that license and monitor them to ensure that there are an adequate number of available practitioners.

### **RECOMMENDATION:**

There is ample anecdotal evidence that managed care has failed to provide access to care for mental health consumers. For managed care to work within the existing structure, systemic changes must occur. The first step must be to substantiate the anecdotal claims by discovering the degree to which there is access to behavioral healthcare treatment and the degree to which phantom provider networks exist. Fact finding should include but not be limited to: data from the managed care providers, the Department of Banking and Insurance which licenses them, and the Department of Health and Senior Services which monitors them, on the list of service providers, the number of claims, number and types of complaints and appeals, etc.; data from consumers and from organizations that represent consumers on the number of claims, number and types of complaints, outcomes, etc.; information on and monitoring of the process of developing and approving contracts; and information from screening centers.

If these claims are substantiated, then they will need to be addressed and resolved through either the regulatory, legislative and/or legal process.