

**Managed Behavioral Health Care in Massachusetts:
A Trade Association Perspective**

by

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Introduction

Mental Health and Substance Abuse Corporations of Massachusetts (MHSACM) is a statewide organization of 100 provider corporations with annual revenues in excess of \$1.2 billion. Its members employ over 20,000 professional and para-professional care givers and support staff who serve over 120,000 clients each day. Its primary payers are within the state and federal governments.

MHSACM stood alone in supporting the creation of Medicaid managed care benefits in Massachusetts in the early 1990's and it did so as a matter of survival. A very bad state economy presented the opportunity to propose and support managed care in the Medicaid program as an alternative to the elimination of all optional state mental health and substance abuse Medicaid benefits. The challenge was to work with the Legislature and Administration to shape a benefit that did not in and of itself minimize access, choice and quality; thus MHSACM lent strong support to the concept of a behavioral health carve out.

Reasons for Success

Massachusetts' leaders and advocates benefited from the mistakes of other states, and began their new plan with solid support of providers because they were not eliminated from initial networks. The Division of Medical Assistance (DMA) fashioned options for consumers that included HMOs and a Primary Care Clinician (PCC) Plan with a mental health and substance abuse carve out. In addition, leadership also listened to recommendations that led to a strong, monitorable contract for a single behavioral health carve-out manager for the PCC plan, rather than multiple contractors. In retrospect, many believe that the concept of a single carve out manager has been a major contributor to success of the Massachusetts program. Others observe that while providers, consumers, family members and advocates have raised many operational concerns, both DMA and the Executive Office of Health and Human Services (EOHHS) have advanced reasonable processes to resolve differences. The professionalism of carve-out management, EOHHS, DMA and the Department of Mental Health (DMH) when combined with the progressive thinking of MHSACM and other advocate groups have continued to influence this evolving product.

Reorganization and Reducing Fragmentation

Recently the state's new Administration reorganized Medicaid, placing the responsibility for Medicaid behavioral health care with the Department of Mental Health. As 65 to 75 percent of people in state-supported care are estimated to be dually diagnosed, this move bodes well for individuals and their families with both addiction as well as mental illness and will undoubtedly result in dual programming that meets the test of best practice. It is also altogether likely that the current community mental health and

substance abuse systems will become less fragmented and that the Commonwealth's mental health, substance abuse, social services, transitional assistance and other agencies will need to work together to make the most of available resources to address confluent needs.

Comprehensive purchasing is just one output of reorganization through which Medicaid managed care can have a positive impact in the future, including quality improvement and cost efficiency.

Collective Problem Solving

MHSACM continues to support the carving out of the mental health and substance abuse benefit. Through the Federal waiver and contract mechanism, DMA has reserved its management rights and exercises them with precision when essential to get a bad idea off the table or a good idea operationalized. The DMA oversight, contractual, and management role has provided a "safety net" for the community system that minimizes stress and maximizes opportunity. For example, in the early days of Medicaid managed care, providers were owed considerable sums of money that were ultimately paid by DMA based on documentation derived through MHSACM providers. Both the state and MHSACM recognized the value of collective problem solving as compared to a more adversarial approach that would render these parties opponents and not partners.

Performance Measurement

MBHP policy requires outcome measurement effective in 2005. For a matter of years, the state and providers debated the need for outcome measurement. Lacking managed care support for a single, cost-effective approach, MHSACM created its own. At this moment, the Massachusetts Behavioral Health Partnership (MBHP), the PCC Plan carve-out contractor, DMA, MHSACM and others are finalizing policy by which the MBHP provider network will implement outcome measurement system-wide. MHSACM is seeking to ensure that any tool adopted is clinically appropriate to behavioral health service modalities and requesting provider reimbursement for the costs of adoption and ongoing implementation of outcomes measurement systems, the goals being exceptional quality and high utility of the information collected. Outcome measurement is just one example of literally hundreds of issues that have been debated in the context of managed care.

The MHSACM Vision for the Future

MHSACM has the following vision for the future: First, the state must assure that there is a single, unified state behavioral health system under the Department of Mental Health. In addition, Massachusetts needs to tackle and resolve integration of substance abuse policy for all human service, education, correction, public safety and judicial settings. The current cost of substance abuse treatment to taxpayers is quadruple that of the Bureau of Substance Abuse budget. Lastly, the state must carve out and combine behavioral health services management for all of the MassHealth products. It is time to eliminate the cost of duplication and to purchase with a single approach.

Second, the state must design and implement comprehensive continuums of behavioral health care in each of the natural service areas. Fragmented services have no place in the systems of the future. Clients and families deserve a service flow that can address their changing needs.

Third, the current silo management of children's behavioral health services must be modified. Part of this problem is the need for centralized state policy, part is the need for better coordination, and part is the need for restructuring Medicaid HMO behavioral health products.

Fourth, the state must work with network providers to devise a simplified way to achieve better primary health and mental health integration in the context of the carve-outs. There are many examples of best practice on this issue, but the system lacks a cohesive approach that is transparent to users and providers.

As behavioral health managed care continues to evolve in Massachusetts, the stars appear aligned to harness the energy of a wonderful group of leaders, seasoned by the experiences of the past 10 years, many of whom are now in state leadership positions. At the same time, the mental health community has the capacity and sophistication to demonstrate to the Legislature the inherent benefits of having Medicaid Behavioral Health housed at the Department of Mental Health and to induce funding reallocation to take complete advantage of this innovative reorganization.