

Provider Perspective

by

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Abstract

The Massachusetts mental health system is so fragile and complex that its survival is at risk. This is not due to managed care, but to inefficient administrative areas and inadequate rate increases. Consumer access and the viability of some agencies are threatened. We need to reduce the administrative burden, pilot new financing structures, and move to a system that can better help providers to serve their consumers.

Provider Perspective

My perspective comes out of twenty years of managing a local behavioral health care system providing both mental health and substance abuse services in southeastern Massachusetts. Our system is linked to the local health care system which operates a physicians' network and an acute care hospital. For the last twelve years I have chaired the managed care committee of our trade association, MHSACM. I've reached the conclusion that our system of community based behavioral health care at present is so fragile and so complex that its very survival is at risk. This is not a result of managed care, but more the result of our financing system that is both poorly structured and inadequate in some critical areas.

There are a number of administrative areas in which we can become more efficient, reduce our costs, and restructure our system in ways that will make us less complex and less fragile. We should begin that process immediately. While the PCC managed care plan as initially structured set the gold standard for adequacy of benefit and opportunities to manage care towards positive client outcomes, it only represents about a third of the covered lives that exist in the Massachusetts Medicaid Program at this time. The second set of managed care programs are our HMOs under contract of Medicaid. We also have the Medicaid fee for service system, primarily, but not exclusively for individuals that are eligible for Medicare and Medicaid. It is this structure that causes a lot of our difficulty at the provider level delivering care on a day-to-day basis. The negative consequences of the system are substantial and create the administrative burden that shifts resources away from client care.

For example, our organization has six different contracts with Medicaid funded health plans for up to twelve different services. An organization may have contracts with four of those organizations but not the fifth and sixth and that is going to limit or somehow shape what the organization is able to provide when a client walks through the door. The type of Medicaid coverage a person has should not influence what services they receive, unfortunately it often does. We also have six different rate structures, six different sets of network reviews and audits, five sets of authorization processes, and five separate approaches to quality care and outcome management. This is an enormous burden. It is hard to see the value added in this structure.

Provider organizations deal with five questions on a day-to-day basis with clients who walk through the door, where we are looking to be their linkage into the behavioral healthcare service system. The first has to do with access, the second with the adequacy of the benefit, the third is the adequacy of the rate, and the fourth is payment (which is distinct from rate and has to do with the likelihood of timely payment) and the fifth is how am I doing as a provider compared to other providers (e.g. everything from responsiveness to clinical outcomes). Looking back over a three-year period ending in June of 2003, the 100 members of our trade association have an average of 14 days cash. That is a fragile system by any standard of measurement and that fragility in my view has much to do with rates as well as these costly administrative burdens.

When the benefit structure of the program was designed, having broad outpatient access as well as a critical care access was an important part of the program's structure. At this time, some of those points of access are diminishing. At least thirty-five clinic sites have closed in the last three years. In addition, many organizations have shrunk their outpatient capacity, very

often only linking those with other specialized programs they may have. We have long waits for psychiatry, particularly child psychiatry. This diminished access has implications for which other services are eventually utilized and client outcomes.

In our own community, for example, we only treat a small portion of those people that we know are in need. One of the programs we operate is a school based counseling program. We are in about thirty schools, mostly low income and minority, in five different communities, and see just under a thousand children. Seventy-five percent of those children would not have access to behavioral healthcare unless we were visible in the schools; for a whole host of reasons they would not make it to another location where care is offered. It has become very, very difficult in the current environment and the current rate structure to be able to provide those services, and we are uncertain as to how long we can continue to do that. Reducing these points of access has negative consequences for a whole set of outcomes for these children.

I work with two comprehensive providers in another community with long and distinguished records of providing access to care in their communities to a whole range of care. At least one and perhaps both are at very substantial risk of not surviving the next 12 to 18 months. Not only will those communities suffer enormously, but the institutions they work with such as schools and health centers are also going to suffer, not to mention hospital emergency rooms, the police and the courts. Some would suggest that this kind of consolidation is one aspect of a greater consolidation of a number of industries, and that consolidation will lead to stronger providers surviving and other weaker providers not surviving. It is not a good place to use market forces; if this continues to erode the local system of care we will end up with less and less capacity in those communities where we need it the most.

One of the most impressive things that the Partnership (MBHP) has done is to support providers of ICM community support services. It is one of the places where services can be improved and costs can be reduced. I think the data on that is quite clear, but recall those three separate categories of Medicaid funded services. If you are in the Medicaid fee-for-service system you have no access to that kind of service coordination. We all know that case management, especially for clients with multiple problems, is really a core service. For us to exclude that from a third of the Medicaid population, especially the population heavily weighted to those with disabilities, is a very substantial limitation of the program that all but guarantees to produce poorer outcomes.

By my calculations, average rates have gone up about 6% in the last twelve years. If you look at any index of medical inflation, that is a 30-35% reduction in real dollars. As a result, clinics are closing, access becomes more difficult, and coordination of care becomes more difficult. I have looked at cumulative financial statements for a four-year period for almost one hundred organizations in our trade association. Forty-five percent of our members do not have a positive operating margin over a four-year period. We better find a way to do something about that or access will diminish and in the end more costly services will be required.

One of the best ways of shaping provider behavior and reducing inefficiencies in the system is to let providers know how we are doing in relation to one another. Benchmarking utilization has been a real area of disappointment. We had some very good outpatient benchmarking going back nearly ten years. We do not have that data now, and it is a distinct

limitation. Even more important than benchmarking utilization is benchmarking outcomes. There are systems, there are technologies that some of us are using now that provides us the opportunity to do that and to do so on a risk adjusting basis. We have to move toward doing that and embracing those kinds of technologies quickly.

Where do we go next? We have to encourage the state to move away from purchasing discrete service elements and towards purchasing a continuum of care that is locally based. We have to move care management decisions to the local provider level. We have to establish system-based outcomes, benchmark provider performance, and align incentives in a way that improves client outcomes. People here have talked about recovery and rehabilitation as part of our system of care. Very often benefit structures and how those are managed do not square up with that kind of policy and those kinds of values.

We ought to move to a single Medicaid benefit structure and reduce some of the administration burden. We should begin piloting prospective per member per month financing structures at the local provider level. I ask you to join with us and move to a system that builds and supports local systems of care, provides ready access and focuses upon treatment outcome through the use of evidence-based practice.