Behavioral Health Access: Improving Provider Availability

New Mexico Interim Behavioral Health Subcommittee

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Present by

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Introduction

- Issue of Access to Behavioral Health Care is an on-going topic of concern and evaluation in NM Behavioral Health System.
- Official reports of increased access and utilization are not supported by individual consumer and provider reports of long delays in accessing service providers and decreases in service availability since 2013.
- Still, four years after 2013 we have ongoing issues of MCO extrapolation of data and trying to recoup payments

Office of Inspector General Evaluation

The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services has notified New Mexico that they will conduct an evaluation of programs within the Human Services Department. The OIG is responding to a May 2017 Congressional request to investigate the accessibility of behavioral health services within Medicaid managed care plans. The OIC is planning to look at five States, one of which will be New Mexico.

For this study, they plan

1. to evaluate the extent to which Medicaid managed care plans include behavioral health providers , and
2. ***Our focus***: the extent to which behavioral health providers are available to meet the needs of Medicaid enrollees.

Access to Care: Provider Availability

Lack of a uniform definition of Accessibility.

Overall, there is a lack of a unifying system that defines relationships between system elements, and provides consistent and evaluative data about effectiveness.

1. Lack of effective monitoring
2. Lack of robust and stable behavioral health providers, therefore lack of a robust and stable system.
3. Provider based workforce issues related to compensation and job stability

Monitoring

As reported to the IHHS committee in October 2015, the current monitoring practices

- Report data inconsistency due to multiple and legacy stakeholder reporting methods, across multiple Medicaid iterations.
- Failed to systematically assess consumer enrollments and service utilization following 2013 closing of 15 agencies and subsequent transition to replacement agencies after Arizona departures. E.g.,
  - Replacement providers, not MCOs nor state entities, were responsible for consumer outreach and follow-up with varying results.
  - Formerly in Roswell The Counseling Center on average billed 22,000 annual encounters; now La Casa de Salud (replacement agency) bills approximately 13,000 annual encounters

Credible monitoring

Does 2013 matter now? Yes….

Based on reports of Medicaid utilization, still cannot accurately assess provider availability. Big discrepancy in reported data/consumer experience.

- Medicaid reports dramatic increases in utilization, but what is the data reporting methodology
- Are the increases reported compared to pre-Centennial Care with Optum?
- Centennial Care data includes Primary care reporting and Medicaid expansion numbers
- The numbers don't fit….. comparing apples to oranges

Credible monitoring should be based on

- A public commitment to "care driven by data"
- The consistent availability of accurate, reliable, generalizable, and valid data to assist lawmakers, government entities, providers, communities and other stakeholders to focus funds, policy-changes and workforce development efforts
- Data reporting that simultaneously represents multiple stakeholder perspectives (e.g., consumers, providers, etc.). reports "apples to apples",
- Hopefully this will be replaced by the Medicaid Management Information System Replacement (MMISR) to be completed by 2018

On-going Administrative Burdens

- Lack of a consistent methodology for efficiently resolving administrative burdens associated with claims processes, regulatory requirements
- HSD: BHSD Strategic Goals: To identify, align, and eliminate inconsistencies in BH statutes, regulation, data and policies. Established 2015, first round of MAD rule revisions planned for late summer 2017. Changing policies and procedures takes too long.
- Establishing reasonable audit practices and reducing related audit risks and potential for "fraud" (Senator Papen's due process bill). Needed protections for providers against incorrect MCO decisions regarding services requirements and billing processes, e.g., IOP as an hourly billable service
- Provider participation: a paucity of provider input in key systems meetings
  - Membership on Medicaid Advisory Committee
  - Voting membership on Behavioral Health Collaborative
  - Membership on Health Homes Steering Committee
- An ongoing lack of incentives and establishment of fiscal priorities for community based services (not just for Health Homes)
  - For example, billing that works for wraparound
  - Rates for community based services, it takes a lot more nickels to add up than the dollars paid to high end, residential services

How Providers become more Accessible

- Our members are 100% committed to improving access and are willing to participate in a variety of program initiatives designed to improve access including. NMBHPA providers are very active in many initiatives including health homes and Treat First
- We believe that the development and implementation of innovative approaches could become much more attainable if timely action was taken on our fundamental operational concerns.

Provider based workforce issues related to Compensation and Job Stability

There are many workforce challenge and issues. For example, October 28 Workforce Summit

Our focus: workforce issues related to compensation.

- Employment costs rising to crisis level. Pending insurance rate increases affecting all employers.
- For a snapshot of impact on New Mexico's behavioral health providers. see next page.
- Based on projected increases from National Council of Legislatures, we used 25% to project increases among our members
- Demonstrates further risks to workforce
- We are evaluating potential help from Insurance commissioner and Exchange at September 11 Board meeting

Health Insurance Projected Increase Snapshot

$ increase assuming 25% health insurance premium increase	Options to absorb increased cost	Current employer/employee cost split
20,000 **36,000** **39,768** **47,238** **54, 635** **93,000** **93,000** **196,252**	1. Decrease plan benefits 2. Increase agency premium costs 3. Increase employee co-pays and deductibles 4. Decrease staff FTE 5. Increase part-time staff 6. Limit planned program expansion/improvement .	• 50 - 100% employer portion depending on length of employment • 90/10 • 60/40 • 66/34 • 75/25 • 89/11 • 82/18

Rate Setting Methodology

2. Lack of a comprehensive rate-setting methodology.
   - Since 2008, Colorado has had a law requiring the state department (HSD) to "complete a review of the methodology by which provider rates, services and outcomes" are evaluated and negotiated. This law applies to child welfare licensed services. https://leg.colorado.gov/bills/hb17-1292
   - In 2017, the Colorado legislature appropriated $300,000 and amended this law to be specific to out of home placements. Colorado is preparing to issue an RFP for a vendor to:
     - Perform a salary survey ad study related to the delivery of child welfare services
     - Preform an actuarial analysis of the costs necessary to provide service at a level required by state statute, departmental rule, or federal rules and regulation
     - Develop a rate-setting methodology for provider compensation using a salary survey and actuarial analysis

How to Build and Stabilize Provider Availability: New Mexico Needs….

1. A comprehensive rate setting methodology, that systematically evaluates and provides the negotiation basis for rates
   - Would bring stability to the negotiation process
   - Would establish fairness and even the playing field, all providers would be evaluated with the same methodology
   - Would minimize salary disparity among employee classifications, agency to agency, and would increase employment stabilization.
   - Colorado children's services is just an example. Could be established for all behavioral health services.
   - Rate Analysis is a NMBHPA 2018 goal - how to fund?
2. An administrative burden reduction methodology, based on provider participation, to ensure efficient claims processing, meeting of regulatory requirements, and providing quality of care.

Legislative Asks

- Support Sen. Papen's bill "Medicaid Access, Disputes & Fraud"
- Support NMBHPA participation on MAC, the BH Collaborative, and the Health Homes Steering Committee
- Evaluate and monitor administrative burden reduction processes and outcomes
- Support a rate-setting methodology requirement
- Legislatively define HSD requirements for Access reporting and monitoring
- Monitor health insurance costs for nonprofits