Reform promises dollars, but not soon enough

Hit hard by recessionary cuts, providers battle their way toward a brighter future BY BRIAN ALBRIGHT

In August, after a lengthy battle, Congress finally extended its "enhanced" federal medical assistance percentage (FMAP) beyond a scheduled expiration in December 2010, providing a 3.2 percent FMAP boost from January to March and a 1.2 percent boost from April through June. While much less than the original FMAP enhancement of 6.2 percent, at least it was on the plus side, right?

"It just postponed the inevitable," says Joe Roszak, executive director at Kitsap Mental Health Services in Bremerton, Wash. "I don't know if Congress will seriously consider another continuation of FMAP in the future, because the deficit is becoming an issue for so many legislators. We've gotten a reprieve, but the endgame hasn't changed."

For providers, the endgame is survival. Given behavioral health's recent and remarkable gains in the public policy front, it's painful to see that some community-based providers are now struggling to survive, both long enough and strong enough, to take advantage of the hard won victories in parity and health care reform legislation.

"We were holding our breath on FMAP," says Shannon Harsey, CEO of River Falls Behavioral Health Center in Mason, Ga. "That's been a blessing for us, and has helped hold our Medicaid rates steady. But Georgia ranks 19th in mental health funding and 9th in population. We started out behind, so the fact that we've had no reduction doesn't mean we're sitting in the cradled seat."
In Kentucky, another state that has not reduced state general funding for core behavioral health services, Howard Bracco, president and CEO of Seven Counties Services in Louisville, says that years of "flat" funding can take a toll: "Over time there's an erosion of capacity, unless you find ways of reducing costs, improving efficiency, or finding alternative sources of revenue to underwrite particular services."

With prospects for major funding changes dim until 2014, when major phases of reform—and related funds—kick in, providers like Harvey and Howard are, like many of their peers, now looking past the FMAP fight. They're trying to figure out how to keep the lights on as a deep and painful recession continues to choke funding, even as they watch a bright, but still very blurry, future take shape. That future promises millions of new consumers and tens of billions in additional behavioral healthcare resources from the federal government and private insurance companies.

But promises don't pay today's bills and the prospects for near-term help isn't good. "The initial projections in Washington state were that this might be over in four years. Based on the analyses I've been reading, these budget issues could go on for eight years or more," says Roszak at Kitsap.

"People are trying to find new funding, but even more than that, organizations are looking for things that might make their systems more efficient, or that can make their limited dollars go a little further," says Robert Glover, executive director of the National Association of State Mental Health Program Directors (NASMHPD).

**Belt tightening: How many notches are left?**

Unfortunately, many providers have been forced to cut back on staff, services, or both as state funds have dried up and revenue becomes more sporadic. In Illinois, where the state budget deficit exceeds $8 billion, providers have seen funding cut by 25 percent in two years and organizations have been laying off staff, eliminating programs and even skipping payrolls.

"Even with the cuts, payments are getting behind," says Sara Moscato Howe, CEO of the Illinois Alcoholism & Drug Dependence Association (IADDA). "The state is only paying when they can. No one is sure when payments will come, and the banks aren't lending like they used to because state revenue is no longer a good source of collateral."

In other cases, though, providers have been able to maintain services by doing more with less. "We squeeze every possible value we can from every dollar," says Harvey at River Edge. "As a result, we've sought to take advantage of technology investments to increase efficiencies."

River Edge has realigned its staffing and scheduling to improve efficiency, and invested in new technologies like an electronic medical record and telemedicine capabilities. Still other providers have implemented lower-cost peer-counseling and group therapy programs where appropriate.

The logic of such improvements is clear to Jonathan Evans, CEO of Safe Harbor Behavioral Health in Erie, Pa. "A big part of healthcare reform is that there are going to be large numbers of people who are going to queue up for care, but there aren't enough providers. So when you are thinking about rural access, for example, programs like this [telemedicine] are going to be key."

**Information technology: Data means dollars**

Thanks to intelligent planning, some providers have armed themselves with the information technology and skills needed to demonstrate their value and impact locally or statewide. For example, Safe Harbor used outcome data to establish itself as the most cost-efficient provider of care for patients with persistent mental illness in its region.

Increasingly, both public and private payers expect claims of value and medical necessity to be backed up with data. "We have a fully integrated electronic health record, and we can't say enough about how valuable a tool it has been," Evans says. With its IT resources, Safe Harbor can track its actual costs per unit of service, track individual patients, and even manage incentive-based productivity contracts with licensed therapists. Safe Harbor has negotiated rates with a local MCO that Evans describes as "sustainable," the basis for a relationship that has helped the organization thrive and expand. But building that relationship has required aggressiveness and persistence. "We're telling them, 'We need to sit down with you and develop a partnership,'" Evans says. "We have some unique programming for chronic disease management and crisis response, and we want to develop a contract to save you money and make sure the people you cover are taken care of."

In Kentucky, Bracco says Seven Counties has provided data to state officials to illustrate the success of its hospital and jail diversion programs. "It has taken years to get that message across, to measure outcomes and translate those into dollars," Bracco says. "We've emphasized services as an investment rather than an expense, and the governor understands that if we aren't funded, then he's going to discover increased costs in other areas."

Data is also essential for internal purposes, as organizations evaluate the efficiency and sustainability of their programs. "Anything we do, we have to do a cost-benefit analysis to determine if the activity is fiscally solvent," Roszak says. "If you pursue a worthy program that is fiscally unsound, you put your agency and your mission at risk. Our mission alone is not enough to keep us in business."

**In 2009...**

According to a Brandeis University study in the International Journal for Mental Health:  

- **32** state mental health agencies reported budget cuts
- **13** states reduced Medicaid payments to providers
- **14** eliminated coverage for some treatments

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Rozsak, for instance, discovered that Kitsap was providing services to a local jail at a nearly $150,000 annual loss. The contract hadn’t been reviewed in over a decade.

"Had we continued to roll that contract over, it was one of those black holes that was gradually making the solvency of our mission unstable."

**New lines of business mean new revenues**

With some sources of state funding evaporating, providers may need to establish new lines of business, or find new populations to serve that will provide additional revenue through contractual payments, direct consumer payments, or services to newly eligible Medicaid populations.

"You have to look at the market out there and say, 'What can I do to meet the needs of these consumers or these systems?'" says Kim Johnson, deputy director for operations at NIAxT.

At Kitsap in Washington, where the majority of funding has traditionally come from state and federal sources, Rozsak says that staff members have pursued specialized contractual services with local public school systems and other entities. For example, Kitsap provides special education services for a number of districts. "We provide some needed services and meet the special education requirements that would otherwise otherwise have to be met through additional school staffing, or residential services that charge four to five times the amount that we do," Rozsak says.

Seven Counties in Kentucky has also launched new business initiatives, including an expansion of its care coordination services for older consumers, including transportation, home visitation, socialization activities and more. "What supports that may be self-pay from families, or long-term care insurance, which are areas we have not tapped into before," Bracco says.

NAMHHPD has been promoting peer support programs, and trying to help members develop programs and bill for those services through Medicaid. "In 2007, the CMS came out with a letter notifying Medicaid directors that peer support was an evidence-based practice, and we now have 23 states that bill for it," Glover says.

**Since 2008...**

State mental health budgets, which had grown steadily for decades, have seen "unprecedented" cuts:

- **2008-09**: 4%
- **2009-10**: 5%
- **2010-11**: 8%


**By 2014...**

According to one estimate, of the 32 million adults who will receive healthcare by 2014, some 10.5 million will have mental health or substance use disorders. The result:

- **$60 billion** more in Medicaid contributions for behavioral healthcare services annually
- **6.3 million** more individuals covered by Medicaid
- **4.2 million** more individuals covered by private healthcare
- **$7 billion** more in private healthcare contributions for behavioral healthcare services annually

In Tennessee, the state invested funds through its Creating Homes Initiative (CHI) to provide housing for people with mental illness. By soliciting non-traditional mental health funding through state and federal housing initiatives (general low-income housing funds with different but applicable criteria), the state has been able to expand the program to include more than 7,000 supportive housing units.

In Georgia, River Edge’s non-profit foundation secured funding to purchase and build new residences for clients. “That allowed us to be the landlord and we can use the rent margin to pay for supportive services,” Harvey says.

Safe Harbor has transitioned from a provider that was 100 percent government funded when it was founded nearly 20 years ago, to one that is now a 75 percent fee-for-service operation. It operates a growing private practice in the community, and is contracted to provide employee assistance programs for 115 companies. “The program is set up so that at the end of the year, any margin realized is donated back to the public entity, so it helps fund the public service through private entrepreneurship,” says Evans.

New directions for outreach and partnership
Behavioral healthcare providers are also reaching out to other organizations, providers, and state agencies to coordinate and pool resources. In Alabama, a shift from state-operated to community-operated services may help trim costs without harming services. For instance, two state hospitals (Bryce and Seabury) are downsizing operations and shifting resources and funds to community-based programs.

“By doing that, we can move funds to the community services, which operate at a lower cost,” says Molly Brooms, director, Office of Community Programs, with the Alabama Department of Mental Health. “We can expand community services appropriately for those individuals, and save money to meet our budget deficit.”

Alabama is also attempting to build bridges between mental health and primary care physicians. The state has received a series of grants funded by SAMHSA, which have been used to convene regional meetings between primary care providers and mental health providers, as well as support a child and adolescent psychiatric institute.

The goal is to improve outcomes through better collaboration, while providing more cost-effective care in the long term. For mental health providers that have electronic health records and can bill Medicaid, such relationships can generate additional revenue via referrals from primary care. “We were able to provide modest grants to six local areas where FQHCs and community centers could come together and develop a plan for how they could improve coordination,” Brooms says.

Texas legislators, faced with full prisons and another multi-million-dollar request to build more, decided instead to appropri-

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**Family Services focuses on planning, data**

At Pittsburgh-based Family Services of Western Pennsylvania, a diversified revenue stream, strategic planning, and a laser focus on fiscal sustainability have helped the organization to thrive within a state struggling with a budget crisis.

According to COO Stephen Christian-Michaels, Family Services has positioned itself as a data-driven agency that emphasizes evidence-based practices. It has partnered with local universities to do outcomes and academic research.

With hard data in hand, the organization has closed some programs that tended to promote dependency instead of recovery. It also launched a certified peer specialist support program that provides a lower-cost means of improving outcomes.

The organization carefully calculates and measures all of its costs, tracking reporting units for each unique service. “We have every supervisor do their own budget, because they know where all the skeletons are in their programs,” Christian-Michaels says. “If we didn’t have that input, we’d be making unrealistic budgets.”

Outcomes data is valuable currency when the agency applies for grants or lobbies state government for better reimbursement rates or new program earmarks. And, as Family Services has found, it’s priceless as the agency engages with more and more private insurance companies.

The organization is evaluating how to improve the efficiency of its outpatient services and is evaluating the use of contractors in addition to employed staff, managing productivity targets and merit pay, and streamlining its collection and co-payment systems.

“The electronic health record is critical to all of this, because getting that data is how we pay for things,” Christian-Michaels says.

Strategic planning is another area of strength. The organization develops an annual operational plan centered on specific objectives. Each goal is assigned to a specific manager or director, who all work against pre-established deadlines. There are measurable objectives for productivity, budgets, raising new funds, and other tasks.

“At the end of the year, this is all worked into the performance evaluation,” Christian-Michaels says. “The strategic plan keeps our oars moving in the same direction.”

Every supervisor in the agency also has to measure the outcomes of agency programs. “We use a logic model which describes the inputs, the outputs, and the outcome objectives,” Christian-Michaels says. “They present these to their peers once a year. We look at what we learned from that data and what they will do next year based on that experience.”

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Recognizing that "data means dollars," providers are capturing and using data to:

- Measure unit costs of service
- Manage incentive-based contracts
- Negotiate sustainable rates
- Demonstrate program ROI
- Evaluate program costs and benefits
- Coordinate care and accept referrals
- Speed claims and improve cash flows
- Provide individualized assessments and services

California seeks bridge to future funds

Although the recent federal healthcare reform package won't be fully implemented until 2014, some states are considering ways to accelerate some of the increased coverage reforms in advance of that deadline.

In California, officials are negotiating a new waiver with CMS to provide a bridge between the state's existing Medi-Cal program and the full-access expansion planned for 2014.

Since 2005, California has had a Medicaid 1115 waiver in place that has been used to provide extra federal dollars for managed care programs, special payments for safety-net community clinics, and other programs. Now, the state would like to alter that waiver to expand a program in advance of reform, providing a bridge to uninsured and vulnerable populations.

Currently, there are ten "coverage initiatives" in California operated by individual counties that provide benefit packages for individuals up to 200 percent of poverty with no health insurance. Provided the localities can come up with the funding, the federal government provides matching funds up to a capped limit to reimburse hospitals for services to the uninsured.

Called the Bridge to Reform Waiver, the proposal would expand the current coverage initiative to all counties in the state. "The state is trying to incentivize the counties to become healthcare coverage initiative locations with some structure that would be consistent statewide, as a bridge to the 2014 reform," says Patricia Ryan, executive director of the California Mental Health Directors Association (CMHDA).

The original proposal did not specify any coverage benefits for mental health, but after a request from CMS related to parity, the state is now drafting a proposed behavioral healthcare benefit package.

According to Ryan, those benefits, under the current proposal, would include up to ten days of inpatient care, pharmaceutical coverage, and up to 12 outpatient encounters per year, among other things. "If approved, then every county would have to provide those benefits to all new enrollees who meet the requirements," Ryan says. "The initiatives could also go beyond those benefits, if they wanted to provide more."

All of this depends on counties being able to come up with matching funds, an ambitious goal given the widely varying level of resources available in each of the counties. Because they are all spread thin, some counties are reluctant to support any package that requires new matching funds.

In August, the Department of Health Care Services received a 60-day extension of the current waiver so that negotiations could continue with CMS on the new proposal. The state is hoping to gain CMS acceptance for a proposed package of benefits, along with a higher cap for coverage.
ments that these agencies have to meet,” says Johnson at NIAx. “Different payers have different requirements. If they require an authorization to start treatment, you have to have a way to do that. If they authorize only a few treatment sessions, you have to have a method to track that.” Increasingly, both public and private payers will be seeking outcomes data as well.

Even with the data, it can still be a tough sell. Safe Harbor, for instance, provides a comprehensive crisis service to individuals, regardless of coverage, but is not reimbursed. “I know we save those payers healthcare dollars, because we help prevent admissions by responding quickly and finding resources for those people other than inpatient treatment,” Evans says. “We’re continuing to try to contract with private insurers in the region, but so far they have not seen the value.”

Tougher decisions on care ahead

Providers and consumers know that, when states face a budget crunch, eligibility criteria for public programs often change. In the effort to manage resources as efficiently as possible, circumstances in Alabama, for example, may “cause us to make different policy decisions about who is eligible, and what they are eligible for,” says Brooms.

Now, some providers face the same difficult choice, requiring them to take a new approach to recovery. “It’s been a huge cultural shift,” says Roszak. “Historically we’ve given clients everything we had for as long as they needed it. Now, we have to assess them for what services they need so we can provide the right services at the right time. We’re not keeping every client in services forever. And those that will need services indefinitely are a highly identifiable population. That’s helped reduce our caseloads and made interventions more effective and efficient.”

Brian Albright is a freelance writer.

Providers are finding that local credibility and staff skills can translate into new, revenue-generating opportunities:

- Special education support for local schools
- Care coordination and socialization for seniors
- Peer support programs
- Supportive and rental housing
- Employee assistance programs
- Private practice, private pay alternatives for care
- Diversion from jail to community-based services
- Relationships with primary-care referral sources
- Cost-effective local alternatives to state-run programs

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