

Medicare/Masshealth Changes Coming Soon: Will Affect People Ages 21-64 with Disabilities

As a mandate of the National Health Care Reform Bill that passed Congress last year, Massachusetts policymakers from MassHealth and the Executive Office of Health and Human Services (EOHHS) are undertaking major changes in the way healthcare is funded. These changes will affect people who are disabled, between the ages of 21 and 64, and have both Medicare and Masshealth – who also called “Dual-Eligibles.”

Their plan is to change from a “fee for service” payment system to medical providers to a “global payment” system. It is not a question of “If” this will happen, but “When.” The majority of the people affected by this new change are people with mental health diagnoses. Most have a major medical condition in addition to their disability. Global Payments are one way that our state is trying to address rising health care costs for people with disabilities.

Currently, most people are in a “fee-for-service” healthcare system, whether they have public or private insurance. In a “fee-for service” system, each time a person has any type of health care, the health insurance pays for the service. Each x-ray, blood test, doctor appointment, hospitalization, psychotherapy session is paid for separately. In the new “Global Payment” system, there is a one sum of money given to a new kind of organization, called an Accountable Care Organization, or “ACO”, at the beginning of each year in exchange for the ACO providing for all the mental health care and medical needs of an individual.

Massachusetts will require doctors and hospitals to come together to form “Accountable Care Organizations.” If there are enough of them, it might be possible to find one with all of one’s medical providers in it, or not. Medicare/Medicaid will deliver the “global” payments to these provider organizations *in advance* for each patient, based on that patient’s expected medical expenses.

For ‘Global Payment’ systems set up in the past, such as HMOs, there has been no reward or reason for doctors to provide quality care for their patients. In fact, there could be said to be a financial incentive to provide less care overall and less quality care from less skilled providers, because the doctors were paid a set amount whether or not the patient received excellent care or poor care. Under the new programs for Dual-Eligibles, the Commonwealth plans to reward ACOs (at the end of each payment period) with more money when their patients’ health improves and take money back from the ACO if their patients do not “do well.”

At least, this is the theory of how the new system is supposed to work. We have many good reasons to be concerned about how this plan is implemented.

One concern is for continuity of care. It is not likely that all of a person’s providers will be in a single ACO. It may be very difficult to find an ACO that includes both the medical and mental health providers we rely upon. To be forced to leave treatment with

psychotherapists and psychiatrists we trust, and have sometimes worked with for a very long time is cruel. It also greatly elevates people's risk of short-term crisis due to being forced to change providers. Perhaps people who only rely upon doctors for the occasional flu or mammogram don't understand that many people with disabilities have close relationships with their caregivers that are not always easily re-established. Each provider is an individual and not "replaceable" with another just because they have the same degree or skills.

Another closely related concern is for access to care. If specialized care or consultation with an expert is needed, but that care or expert is not in the ACO, a person will find it hard to go outside the ACO. The ACO will likely put their financial interests before our clinical needs in these types of cases. Another related concern is that ACOs will limit medical providers' freedom to choose the best care for a person, if it is expensive or experimental.

This leads into a concern over our rights. As Medicare clients, we had specific rights and the Medicare rights center to which we could appeal if we disagreed with the decisions of a doctor or facility. What rights will we have and where will our Center be to challenge the decisions of our designated ACO? What is our due process? Can we sue an ACO if they deny us care and it results in damages?

When money is used as the motivating factor to reduce costs and care, all kinds of problems will likely ensue. Who watches the ACOs? To whom are they responsible – other than for aggregate results? Are there regulatory bodies or appeals processes for obtaining care that is refused? These are some examples of the critical questions that must be answered - with a concrete system for protecting the rights of all of the people who are being used in this social experiment in healthcare.

However, since services will be approved through current Medicaid guidelines, will the services we recover in partnership with be considered "medically necessary?" Even though the results would be increased mental and physical health, will any ACO invest in our whole health, or will they just look at their yearly bottom lines? Will policymakers be concerned about our needs, or will mental health care be, as usual, cut back, despite our need for them. How many more lives must be lost – not to violence which is not characteristic – but to the mental illnesses and a system that still, despite many people's best efforts, still traumatizes more than it heals.

It comes back to a basic question – "How will health outcomes be measured?" Will only reduction in crises and stays in inpatient units be considered or will the measures be based in newer but proven practices and recovery? It is uncertain when different groups of the insured will be asked to join an ACO and there is a general lack of information about how they will work.

We are concerned about the choice of mental health related services to be covered. There are services that we want and require for our recoveries that *are not medical* and are not part of the medical model. The "Medical Model", in summary, is based on doctors

making the decisions, using primarily medication and hospitalization. A person's diagnosis, medications, and clinical language are central to the medical model, in which psychiatrists are "The Experts."

The "Recovery Model" is one in which the person with a diagnosis is "The Expert" on him or herself. The person chooses what kind of care she or he wants. A person's "treatment" may include "medical model" elements if the he or she wants them, but adds options for peer support, tools for building a support system, and provides for access to respite care instead of hospitalization whenever possible, peer respites largely preferred.

The Recovery Model supports services provided in mutual relationships and decisions about medication made in a respectful cooperative way that includes alternatives. Trauma related to diagnosis and treatment are mindfully reduced and addressed as a systemic issue. A person's level of hope, connections to a peer community, and faith that full recovery is possible – these are some of the key elements of the Recovery Model of care.

Some of the services people with mental health conditions want and would greatly benefit from with improved mental and overall health results are: person-directed case-management, psychiatry and/or psychotherapy services with providers of our choice, certified peer specialist services, ER diversion, peer counseling in the ER, a statewide system of peer respites, low-cost gym memberships, "life coaches", and weight-reduction programs. We also need psychosocial rehabilitation services provided in a spectrum of improved community based settings, the "safety-net" services redux, but a system built on best-practices with the goal of helping people recover their lives again.

There are not many people with concerns about people with mental illnesses "at the table" during discussions about Global Payments. Services for people with mental illnesses, if discussed at all in the design of health care services, are usually an afterthought. Parity, having our disabling conditions entitled the same insurance coverage as disabling physical conditions, is not achieved yet in Medicare and does not cover many of the treatment settings, diagnoses and modalities we need.

It is important for people who themselves are dual-eligible and have mental health diagnosis to be involved at every level of decision-making, not only representatives of the professional organizations that provide certain medically based services to us. We also want to be involved after the system is established, on quality-management monitoring boards and other decision-making groups both in MassHealth and within the ACOs, so that representatives of our community and other disability communities' voices are heard over the long term to make these changes have a real impact on both wasteful spending and quality services.

This will only happen with your help and your voice.

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Next Quarterly Stakeholder Meeting

Patient Protection and Affordable Care Act Implementation meeting
Tuesday June 21, 2011 from 3:00-4:00 P.M.

1 Ashburton Place, 21st floor, Boston

For more information about Global payment reform contact:

Disability Policy Consortium (for persons with all disabilities)

(617) 542-3822 and (866) 745-0917)

The National Empowerment Center (for people with a mental health diagnosis)

(978) 685-1494 and (800) 769-3728)