

**The Efficiency and Quality of
Commercial Mental Health Care in Southeastern Pennsylvania**

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Executive Summary

Magellan Behavioral Health (MBH) manages 99% of the HMO and most of the indemnity market for behavioral health in Southeastern Pennsylvania. The Pennsylvania Psychological Association (PPA) gathered data on MBH from the Pennsylvania Department of Health, Pennsylvania Health Care Cost Containment Council (PHC4), and personal reports and survey data from psychologists.

With some exceptions, MBH does a good job in facilitating psychiatric hospitalizations when they are clinically indicated. PPA commended MBH for its innovative Assertive Community Treatment Program.

However, MBH's administrative procedures divert considerable resources away from and often disrupt patient care. These problems can be found primarily in authorizations, billing, credentialing, and appeals. The authorization process is expensive and cumbersome, contributes nothing to patient care, and often disrupts the continuity of patient care. The billing process is complicated by the frequency with which MBH or the insurer loses the authorizations or fails to process them on time.

Usually the credentialing and recredentialing process runs smoothly. However, when mistakes occur they are extremely hard to correct. Psychologists and other mental health professionals are often decertified through computer or clerical errors. In the 2003 Annual HMO Reports to the Department of Health of Independence Blue Cross and Aetna, MBH claimed they process 100% of new credentials within 30 days and 99% of recertification applications within 30 days. This claim is inconsistent with the reports of psychologists.

The patient appeal process is flawed. In those same HMO Reports, Independence Blue Cross and Aetna reported 42 first level patient appeals in behavioral health. None were found in favor of the patient. This suggests a de facto policy of always rejecting first level patient appeals.

It was estimated that between 38% and 49% of the moneys spent on outpatient mental health care go toward administration rather than patient care. (When excluding patient copayments, the administrative cost could be more than 50% of outpatient health care costs.) These administrative procedures also interfere with and degrade the quality of patient care. The report identified problems in the interpretation or implementation of Pennsylvania's Act 150, Act 68's clean claims process, and Act 68's patient appeals process.

It is recommended that MBH and its primary insurers address these problems. Appropriate governmental authorities should review the practices of MBH and determine what legislative or legal actions are needed to better protect patients.

Introduction

Any discussion of the quality of commercial mental health care in Southeastern Pennsylvania (defined as Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties) must focus on Magellan Behavioral Health (MBH), which subcontracts with Aetna and Independence Blue Cross (IBC), the two largest health insurers in Southeastern Pennsylvania.¹ MBH administers 99% of the HMO and a very high percentage of the non-HMO behavioral health services provided in Southeastern Pennsylvania.² (However, Aetna intends to discontinue its relationship with MBH at the end of 2005.) In addition, MBH administers many of the EAPs and has Medicaid contracts in Southeastern Pennsylvania.³

This report describes the efficiency and quality of commercial outpatient mental health care delivery in Southeastern Pennsylvania. The report was developed in response to complaints by mental health professionals about the impact of the large administrative burden on patient care and health care resources. Of course, some problems will occur with all managed care companies and insurers. Some patient authorizations will get lost, some bills will not be paid on time, and some bureaucratic procedures will interfere with patient care. However, the frequency and magnitude of these problems in Southeastern Pennsylvania appears especially problematic. Also, when an organization has a monopoly on the delivery of health care, the consequences of any mistakes will be greatly magnified.

To its credit, MBH has established some exemplary programs. For example, it has established the Assertive Community Treatment service initiative to improve care for Medicaid beneficiaries with serious mental illnesses in Delaware County. This is a time-intensive program with empirical evidence that it can reduce the hospitalization rate and improve the quality of life for persons with serious mental illnesses.

Also, MBH has made some efforts to improve quality of care such as through monitoring the time it takes providers to answer the phone, or the time it takes providers to schedule routine, urgent, or emergency patients.

This report does not criticize any particular individual or individuals working for MBH. Indeed, providers reported that some MBH staff (especially the network coordinators) go to great

¹According to information on its own Web site, Magellan ranks 817 on the Fortune 1000 list and 33rd among Fortune magazine's largest health care corporations. It has a total enrollment of 60 million individuals, covers the needs of one in four insured Americans, and has 30% of the total market share. It projected \$1.81–\$1.83 billion in revenue and a segment profit in the range of \$200–\$220 million for 2004.

² A review of the data from the Department of Health's 2003 Annual HMO reports shows that MBH administers 99% of the behavioral health for HMOs. Data on non-HMO products was not available, but it is believed that they administer a very high percentage of the behavioral health services for other commercial health care products.

³ Independence Blue Cross (IBC) offers many products. Our review of their Web site reveals that they offer Keystone Health Plan East HMO, Keystone Direct POS, Personal Choice PPO, Personal Choice HSA, traditional indemnity, and various Flex Copay and Flex deductible options. IBC also administers some products in New Jersey, such as AmeriHealth HMO and AmeriHealth PPO, which cover some Pennsylvania residents who work in New Jersey. According to the 2003 Annual HMO Report submitted by IBS to the Pennsylvania Department of Health, the copays for these programs vary from \$0 to \$40.

lengths to protect patient welfare and ensure the quality of services. In fact comments about specific individuals were almost universally positive. However, those conscientious staff often appear to lack the authority to correct problems brought to their attention.

Furthermore, we have no way of discerning how many of the problems are due to MBH's policies, the policies of the primary insurers, or both.

In generating this report we are aware of the biases that may occur when a professional association reports on a managed care company. Nonetheless we have tried to fairly represent and document relevant information.

Also, the authorization, billing, and credentialing procedures of MBH are exceedingly complex. *A completely thorough description would overwhelm the reader in minutiae. We have tried to describe them as clearly and accurately as possible without going into all of the rules, nuances, exceptions, and unwritten understandings that govern the process.* Furthermore, the MBH-administered contracts for IBC have different procedures than the MBH-administered contracts for Aetna. In addition, it was sometimes hard to clarify what the actual procedures are. The psychologists we contacted sometimes had been given contradictory information on the proper procedures for authorizations or billing. Sometimes they believed that their only option is to "bill and wait and see what happens."

These caveats notwithstanding, this report concludes that substantial, recurrent and pervasive problems undercut the efficiency and quality of mental health care in Southeastern Pennsylvania. Patients are suffering.

Much of the problem involves routine administrative burdens. However, many problems involve idiosyncratic and unpredictable burdens that substantially harm the continuity and quality of patient care and waste resources.

Sources of Data

Our review relied on the 2003 Annual HMO reports submitted by Independence Blue Cross (IBC) and Aetna to the Pennsylvania Department of Health. We have also relied on the reports of the Pennsylvania Health Care Cost Containment Council (PHC4).

In addition, we surveyed 458 psychologists. Every fifth psychologist licensed by the Bureau of Professional and Occupational Affairs and identified as living in the five counties of Southeastern Pennsylvania (Bucks, Chester, Delaware, Montgomery, Philadelphia) was sent a survey. Fourteen surveys were returned as undeliverable. A total of 215 useable surveys were received. The results of the survey can be found in Appendix A.

Participants were told that \$1 would be sent to the National Alliance for the Mentally Ill for every survey that was returned. The survey was mailed on January 28, 2005, and a reminder postcard was sent one week later. The survey asked psychologists about their MBH experiences from September 1, 2004, to January 31, 2005. September 1, 2004, was chosen because that was the date when MBH instituted some major policy changes in the delivery of health care.

The survey data was analyzed by Dr. Thomas Bowers, Professor of Psychology at the Pennsylvania State University (Capitol Campus) and Ms. Karen Gibson, a graduate student. The authors assume all responsibility for the interpretations of the data.

In addition to quantitative data, the survey also permitted respondents to write in detailed comments as appropriate. Some representative responses are recorded in this document.

Of the 214 respondents, 34% were in-network providers and 43% of those saw more than 21 MBH patients per week. Since the average psychologist engages in 21 hours of direct patient service per week (Bowers & Knapp 1993), we conclude that psychologists who saw 21 or more MBH patients per week relied almost exclusively on MBH for their third-party reimbursement. It is not known how many of the other psychologists had a greater mix of third-party payments (Medicaid, Medicare, other commercial insurers) or had only part time psychotherapy practices.

Finally, we have relied on the personal experiences of many providers in Southeastern Pennsylvania. Most of them, though not all, are psychologists.

Findings

This review covers authorizations, billing, credentialing, hospitalizations and case assistance, appeals, and other issues. As stated in the Introduction, psychologists are sometimes given contradictory information on what procedures to follow. Despite great attempts to learn the accurate procedures, we cannot ensure that we have done so.

Authorizations

MBH typically requires precertifications through authorizations (called Treatment Request Forms, TRFs) before mental health professionals can deliver services to patients. MBH is not obligated to reimburse for services given in the absence of an authorization. However, the presence of an authorization does not ensure reimbursement. Depending on the contract, MBH may verbally agree to pay for some unauthorized services, or pay for them with a 20% penalty if it does not have an authorization on file.

Typically services are preauthorized for 6-8 sessions during a limited time period. The TRFs may include psychiatric and/or psychotherapy services or some combination of them. MBH requires authorizations for every one of its contracts. Each separate authorization is given a 26-digit number that must be included on the billing form. To its credit, MBH has simplified the TRF to one page and allows mental health professionals to submit reauthorizations over the computer, although problems with this procedure are described below.

MBH almost never denies services on the basis of the medical necessity described on the authorization form. Several provider groups reported that they cannot recall ever having an authorization denied. This calls into question the need for the time-intensive authorization process.

Aetna/MBH and Personal Choice/MBH have an “authorization free” review policy of eight sessions for some of its beneficiaries. However, this authorization-free policy has problems of its own which will be described below.

Administrative Burden of Routine Authorizations

In theory the authorization process should run smoothly. In reality it often does not. Authorizations are frequently burdensome to get and are often not processed in a timely manner, thus disrupting patient care. Furthermore, they often include clinically contraindicated restrictions (restrictions that are detrimental to the patient's care). The authorization process is described in detail below and also represented on Table One.

Mental health professionals estimate that it takes them and their clerical staff about 15 minutes to complete each TRF. These have to be transmitted to MBH, which processes and returns them to the professional. A 26-digit number must be transcribed by administrative staff, leaving much room for data entry error on both sides. To minimize errors the administrative staff needs to double or triple check each authorization number.

It is possible to receive authorizations for the initial appointment over the phone with the MBH office in Georgia. However, this office will consider only 3 authorization requests at a time. Consequently, providers using this option will obtain 3 authorizations, hang up, call back, be put on hold for an average of 20 minutes, obtain 3 more authorizations, hang up, call back, and continually repeat the process until all of the authorizations are received. Often staff has to work past regular office hours to get these authorizations to ensure that patients scheduled for the next day have their authorizations approved.

As noted above, some policies (Aetna HMO and Personal Choice) have an authorization-“free” policy for 8 sessions. For these policies, MBH does not require an authorization for the first 8 sessions. If the patient and the professional decide it is medically necessary to use more than 8 sessions, then the professional must complete a TRF and send it to MBH. However, Aetna/MBH and Personal Choice/MBH will not authorize the TRF until they receive and process the billing for the 8th session. Even if the billing is sent immediately after the 8th session, the time spent by Aetna/MBH and Personal Choice/MBH usually results in an interruption of service. Although the provider may continue to see the patient because of clinical need, Aetna/MBH and Personal Choice/MBH will not backdate the authorization, and consequently not pay for that treatment, thus penalizing the mental health professional for providing continuity of care.⁴

For all MBH policies, having an authorization does not necessarily mean that the services will be paid. For example, an authorization may be given for services that exceed the patient's yearly benefit limit. If providers do not keep track of the utilization and the benefit limits, then they will not be paid for treatment, even if it was authorized. These payment denials often occur when a patient is seen in more than one mental health setting in a year. Although each mental health setting may be able to track its own service delivery, it must rely on the self-report of the

⁴ The disruptions in medically necessary care because of the authorization process could be the basis for an appeal to the Pennsylvania Department of Health. However, by the time the appeals could be heard, the treatment would have resumed.

Table One
Authorization Sequence

<u>Overt Process</u>	<u>Paperwork Requirements</u>	<u>Representative Frequent Pitfalls</u>
Patient calls for appointment	Call to determine eligibility and/or eligibility and authorization	Incorrect information is given concerning eligibility Repeat calls may be necessary to confirm benefits
First appointment (intake)		
First Authorization ⁵	Complete authorization with 26 digits	MBH does not receive or loses TRF TRF sent to wrong address
Treatment Begins	Mail in authorization Check that MBH has received it Receive approval/file approval OR call for authorizations for 3 patients, hang up, call back, be put on hold for 20 minutes, get authorizations for 3 more patients, hang up, etc.	Incorrect provider name or facility Provider incorrectly labeled out of network Patient misinformed about benefits 26-digit number recorded incorrectly MBH reports lost authorization when billed; provider must retrieve authorization from file, re-bill When refiled the second bill may be rejected because it was not filed in a timely manner MBH fails to respond to requests for information about status of authorization
More Authorizations (beyond initial 6-8 sessions)	Submit reauthorization Request backdating if necessary for continuity of services	Aetna/PC will not reauthorize until 8 th session is used and billed thus creating a gap in treatment
More Treatment (If needed)		MBH does not record verbal promise to backdate TRF; professional needs to appeal, refile or lose reimbursement 20% penalty for some unauthorized sessions OR lose reimbursement Provider is not informed of the benefit limit, loses payments

⁵ Aetna/MBH and Aetna/Personal Choice grant the first 8 sessions “free” (without precertification).

patient as to the extent of their utilization with other mental health professionals. MBH will not share this information. If patients under-report their utilization, then the second professional will not be paid for the services that exceeded the yearly limit. MBH prohibits the professional from billing patients for these additional sessions.

Often providers cannot follow up on appointments to active patients because they have yet to receive the authorizations. Of course, this is upsetting to the patients. At times MBH will give a verbal assurance that providers can go ahead and treat. However, these very claims will often be later rejected because the professional has no written authorization. One psychologist commented that “eventually MBH comes through and pays the claim but only after much administrative effort.”

Authorizations Not Processed in a Timely Manner

According to the 2003 Annual HMO report submitted by IBC to the Pennsylvania Department of Health, MBH reported that, in response to a survey question, in 2002, 70% of their providers were satisfied with the timeliness of the authorization process and in 2003, 62% were satisfied.

The PPA survey did not include a question comparable to the one on the MBH survey. However, the PPA survey suggests substantial problems in the timeliness of the authorizations. The survey showed a median of 2%-5% of authorizations involved MBH delays that interrupted services. When these delays do occur, psychologists varied on how they responded. About 58% of psychologists almost always authorized to continue to treat the patients, presumably because the need for care is urgent or based on a verbal commitment on the part of MBH staff that it will back-date future authorizations. However, 27% of psychologists seldom go ahead and treat patients in the absence of an authorization and will presumably only continue to treat the patient if the need for care is urgent.

If MBH loses or fails to properly record one of these authorizations, then it will deny reimbursement to the treating professional. MBH often delays recording its own authorizations and sometimes rejects claims based on the lack of authorization when, in fact, the professional has a copy of the authorization on file. At times the authorizations are lost or not recorded. Experienced providers have learned to double-check any authorization if they do not receive verification within four weeks. One psychologist reported that many times MBH will reject claims because it does not have the authorization on file, but when the bill is re-submitted, it will deny the claim because the billing was not done in a timely fashion.

To its credit IBC/MBH will often honor the providers' requests to backdate an authorization which it has lost. However, MBH's internal system does not always record these verbal agreements, and the providers have the burden to prove that the promise was made. As noted above Aetna/MBH does not honor those requests. One group provider reported that about 1% of its MBH claims are not being paid because Aetna has refused to back-date the TRFs that it received. However, MBH recently announced that, as of March 2005, it will no longer back-date authorizations by more than two weeks. Given the multi-week time lag involved with the authorization process, this new policy will result in more disruptions in patient care.

Three steps are required to correct a clean authorization (where an authorized service has been denied because of MBH error). The professional or staff must double-check paperwork to ensure that the claims are indeed clean, call MBH, which then must search their records and update their systems, and then send the documentation to the insurer. One group practice estimates that this takes 30 minutes per adjustment. (Assuming that the total cost of an hour of clerical staff is \$36 [including salary, benefits, work station costs, etc.], then it costs \$18 to “clean up” an authorization.)

Clinically Contraindicated Restrictions on Services

Although MBH almost never denies authorizations on the basis of medical necessity the authorizations often contain arbitrary restrictions that impede patient care. The PPA survey found that almost 23% of providers had more than 50% of their authorizations approved with clinically contraindicated restrictions.⁶ (The median was 11%-20% of authorizations had clinically contraindicated restrictions on service.)

An example of a clinically contraindicated restriction would be the time limits in which the services have to be delivered. They may vary from 2 months to a year. There is no discernible pattern to these variations. If the services cannot be delivered within the restricted time period, then the providers have to resubmit authorizations, again resulting in unnecessary paperwork and the potential for a disruption in patient care.

Sometimes the authorizations are given for only 2 months. Thus a patient who was authorized for 8 sessions in a 2-month period must use all of those 8 sessions or lose them. Although most patients will be seen once a week or once every two weeks, the restricted time period does not account for patient cancellations because of an illness or another legitimate reason. Also, the number of sessions authorized does not vary according to diagnosis. Consequently, patients with serious and persistent mental illnesses will receive authorizations for only up to 8 sessions at a time, even though their condition indicates that considerably more sessions would be clinically indicated. This occurs even for patients who are covered by Pennsylvania’s Act 150, which mandates a minimum of 60 outpatient sessions.⁷

Magellan almost never authorizes psychological testing and, when it does, the time it authorizes is inadequate to cover the time needed to complete the procedure.

At times, due to apparent computer error, MBH will change the authorization date. This necessitates administrative time in correcting or adjusting to the error.

⁶ The frequency with which psychologists encountered clinically contraindicated restrictions may reflect the extent of their dealings with Aetna/MBH or IBC/MBH. Aetna/MBH appears to place more clinically contraindicated restrictions on services than IBC/MBH.

⁷ Pennsylvania’s Act 150 of 1998 mandates enhanced benefits for patients with any of eight diagnoses indicating a serious mental illness (major depression, obsessive-compulsive disorder, schizophrenia, bipolar disorder, schizo-affective disorders, delusional disorder, anorexia nervosa, and bulimia). Act 150 applies to employers of 50 or more employees who are regulated by Pennsylvania law.

Also authorizations from Aetna/MBH often restrict the type of services that can be offered. For example, an adolescent patient may receive authorizations for 4 sessions of individual therapy and 4 sessions of family therapy during a limited time period. If the psychologist were to deliver 5 sessions of individual therapy during this time period, then that psychologist could not collect payment for the 5th session of individual therapy.

One professional asked for four 90862 sessions (medication checks) for a patient. However, Aetna/MBH authorized nine 90862 sessions within a limited time period. Although this may not seem like a problem, it was because of the need to resubmit additional TRFs (and anticipate delays in its approval).

Another psychologist requested 8 outpatient psychotherapy sessions, but was approved for 3 psychotherapy sessions and 11 psychiatric visits. Although MBH corrected the error, the professional had to contact Aetna/MBH, the case manager had to contact the supervisor, and the provider had to call back later to verify that the change had been made. Of course, the patient has to be kept informed of the process. Most providers instruct their clerical staff to wear headphones so that they can be busy on other chores while they are put on hold waiting for the MBH staff to work through the situation.

These examples are representative of the problems involved. Many more examples could be provided.

These arbitrary restrictions are clinically contraindicated. No mental health professional can predict on the basis of one initial interview what the optimal mix of family and individual therapy sessions should be. MBH mismanages services and inhibits providers and patients from working together to use their collective judgment on the optimal manner to proceed with treatment.⁸ It also limits the ability of patients to utilize the benefits to which they are entitled by contract.

Other Administrative Burdens

At times MBH fails to indicate that an individual may qualify for enhanced benefits under Act 150, thus resulting in authorizations that incorrectly state that benefits are exhausted. Also, when inpatient benefits are converted to outpatient benefits as allowed under Act 150, the insurer will require the patient to pay the outpatient copay, instead of the reimbursement schedule for inpatient care which would not have a copay.

In 2003 Aetna/MBH changed its policy so that authorizations were to be opened in the name of the facility, not the individual professional. However, many consumer service representatives continued to ask patients for the name of the individual professional. If they could not find the name of the individual professional (perhaps because of a misspelling of the name or searching for address of satellite offices, etc.), they would refuse to open the case. This results in added stress and frustration for patients who sometimes cancel appointments until the problem is rectified. The MBH directory often includes abbreviations of the names of

⁸ One of the basic principles of health care is to respect patient autonomy except in highly unusual situations (Beauchamps & Childress, 2001).

group practices. However, many patients have been told by consumer representatives that a practice was not “in-network” because the consumer representatives did not know the abbreviations used in the MBH directory.

Furthermore, administrative problems occur when mental health professionals have more than one practice location. Authorizations sent to an incorrect practice location result in an additional administrative burden for the professional.

Other errors creep into the system. For example, in February 2005 many providers received a letter from MBH indicating that any Personal Choice authorization that went from 2004 into 2005 was “done in error.” As a result providers had to comb through their Personal Choice authorizations and resubmit them. Billing software systems have to be readjusted, resulting in another increase in costs.

Although MBH/Aetna has developed an Internet system for processing reauthorizations, our providers report that this system is often extremely slow and impractical to use. Also it adds another step in the administrative process as secretaries must input the TRF information.

Administrative Burden Summary

The administrative burden of authorizations includes both the time the professional needs to create the authorization and the secretarial staff to submit the authorization, input it into the billing software program, notify the provider, and file a hard copy of the approval. The administrative cost must also include time spent to correct the authorizations that get lost, and time spent talking with patients about lost or delayed authorizations, or incorrect information on the authorizations. Furthermore, providers need to assume some services will never get paid for because of the failure to honor a verbal request to backdate an authorization even if the patient’s condition required continuation of services.

Other administrative burdens are more atypical, but include authorizations sent to the wrong address, authorizations given to facilities when they should have been given to individual providers, and confusion as to whether authorizations expire at the end of the year or not.

Authorizations (or the lack of authorizations) often confuse and upset patients. Patients often get inaccurate letters stating that they have no authorization for services. Most commonly the authorizations have already been submitted and approved, but MBH has not yet processed them. Patients suffer because of confusion about the status of their benefits and the continual possibility of interrupted care.

Although providers try to have clerical staff do as much of the work for the authorizations as possible, it is always necessary to include the professional staff, or at least keep them apprised of the status of patient authorizations. Of course, providers have to apprise patients of the status of authorizations as well.

We were unable to discern any manner in which these authorizations improved the access to or quality of care.

Billing

Providers reported many problems with the MBH billing system. Of course, all institutions will inevitably make some errors. However, when that one subcontractor controls 99% of the commercial health care in a geographical area, those mistakes can be catastrophic for treating providers. The billing problems described in the section below are summarized in Table 2.

One group provider noted that at times MBH will reject claims because the mental health professional allegedly failed to include both the provider name and the facility name, even though both were recorded on the claims form. Another provider reported that customer representatives sometimes give contradictory information as to why a claim was rejected. Another group provider reported that they have submitted a batch of claims to Georgia (regional administrative headquarters for MBH) for the fourth time, with no assurance that this latest submission will be paid. Reportedly the last batch of claims had been accidentally “deleted.”

MBH mandates the submission of paper claims for all HMO services, replacing an electronic filing system that used to take 5 minutes to transmit at little cost to the provider or MBH. The increased cost associated with this change was fully absorbed by the provider.

One large-group provider kept track of the MBH bills and found that about 5% of clean claims are not paid within 53 days. (Pennsylvania’s Act 68 requires clean claims to be filed with 45 days, but the provider added another 8 days in the unlikely event that a mailed payment took 8 days to reach the provider.) It took an average of 134 days to pay these late claims, although this does not account for 50 claims from before August 24, 2004, which still are not paid. MBH has never paid any interest on any of these claims as Act 68 requires.

Billing problems also occur when MBH erroneously classifies an in-network provider as an “out-of-network” provider. These mistakes occur frequently without apparent reason. They will be discussed in greater detail in the section on credentialing. This “decredentialing” has happened to several provider groups in the last year. Sometimes the MBH case managers simply report to patients that a group is out-of-network; at other times the MBH billing system suddenly considers them out-of-network. The net result was that patients who cannot afford to pay for out-of-network providers will lose continuity with their treating professional.

Atypical problems that cannot be placed into any general category frequently occur. For example, providers were assigned new provider ID numbers at the start of 2005, although no providers were notified of this change until after some of them had

Table Two
Common Reasons for Non-Payment of Clean Bills

Treatment was not authorized.

For example, MBH might not honor a verbal promise to back-date an authorization

Patient welfare required providing services and the patient could not wait until MBH processed the requests for more services

Patient welfare required providing a specific procedure (such as individual therapy) whereas the authorization only permitted another procedure (such as family therapy)

MBH refuses to pay bills which their system has not accepted within a specified time period (even if the provider has evidence that the bills were submitted)⁹

MBH did not record the authorization when the bill was first submitted; when the bill was resubmitted it was rejected because it wasn't filed in a timely fashion even though MBH gave authorization, it does not upload this information to another part of its system in time and thus rejects the claim outright or pays it after subtracting a 20% penalty. Provider sometimes can get this 20% back after substantial effort.

Psychological testing provided but not paid for, or the amount of time authorized was not sufficient to cover the time spent

Initial intake or psychological testing not paid for because the diagnosis was not covered by MBH

Billing "lost" by MBH

For various reasons, MBH's system refuses to accept the submission of provider bills; sometimes it gives no notice why a claim was rejected.

Error learned too late to resubmit within prescribed time period

MBH did not record verbal agreement to back-date authorizations

Provider "decredentialed" without notice or mistakenly paid as an out-of-network provider.

Bills submitted more than 60 days after the delivery of service may not get paid, usually because of an error in the authorization process

Authorizations exceed the benefit limit because the patient under-reported the extent of services received from a previous mental health treatment provider

The service was delivered more than 14 days before a 14-day back-dated authorization

⁹ These issues often hinge on what constitutes acceptable proof. Experienced group providers now know to ensure documentation of all receipts or at least document conversations ensuring verbal acknowledgment that the bills were received. Other providers who were not so careful (or more trusting) have lost thousands of dollars of revenue.

already submitted claims and had them rejected. In addition, the new provider ID number was such that it took some adjustment of the computer software before at least one provider group was able to send it. After that group made the necessary change in their software, they were informed that the electronic claims submission for November and December 2004 had been lost. Then, when those claims were resubmitted, they were rejected because the provider numbers were incorrect and the claims had to be reprocessed by hand using the old provider numbers. As of the writing of this manuscript, most of those claims still have not been paid, resulting in the nonpayment of \$40,000 to this provider group. Consequently, the group has had to extend their credit line with the bank.

One large group provider reported that twice they have submitted large bills to MBH, received confirmation that the billing was received, only to call a few days later and to be told that the billing information was never received. More than \$220,000 was owed as of February 2005 to that provider.

Pennsylvania's cleans claims provisions of Act 68 do not appear to be helpful. Although a claim may be submitted with all of the needed information, MBH does not consider it "clean" unless its own computer system has the necessary data. Consequently, claims have been rejected because the MBH system reports that there is no authorization, when in reality there is an authorization, but MBH or IBC has not yet entered it into its computers. Providers are reluctant to file complaints about these violations of Act 68 out of fear of retaliation. One provider who did file a complaint with the Insurance Department found his entire group practice decertified one week later. It took him a month before his group became recertified. Since MBH periodically decertifies individuals and groups due to computer or clerical errors, it is not known if the decertification was accidental or deliberate.

Patients often receive explanation of benefits forms (EOBs) that incorrectly tell them they no longer have authorization for visits. Consequently patients act on this misinformation and cancel appointments thinking that they are out of visits, and are upset that their treatment is not covered.

For example, a patient was eligible for expanded benefits as mandated by Act 150. Nonetheless, he was erroneously told that his benefits had expired and dropped out of treatment. As of the writing of this report, the treating providers are still trying to get MBH to correct the inaccurate information. It is difficult to estimate the emotional harm when patients receive such misinformation.

Credentialing

The survey showed that psychologists rated the credentialing process with MBH as 4.5 on a 7 point scale (1 indicating very poor and 7 indicating very good). Of course, this question was asked only of persons who were already in-network. Other psychologists who applied to become credentialed and were rejected would obviously not be satisfied with the process.

The 2003 HMO Annual Report submitted by IBC to the Pennsylvania Department of Health stated that 77% of providers were satisfied with the credentialing criteria. Of course,

satisfaction with the credentialing criteria is a different issue than satisfaction with the credentialing process.

The same HMO Report claimed that MBH reviewed 100% of the initial credentials within 30 days of receipt by their CVO (Credential Verification Office) and over 99% of the reauthorizations within 30 days of receipt of their CVO. These figures give an impression of efficiency that varies substantially with the reports of the PPA survey and the anecdotal report of psychologists. Although some psychologists had an easy time with recredentialing, other psychologists had their recredentialing applications repeatedly lost or delayed. Perhaps MBH is recording information on its internal records, not information on when the provider or primary insurer has been notified.

Providers gave numerous examples of when delays in credentialing interrupted patient care. One group practice had a psychiatrist who died suddenly. MBH was contacted and asked to expedite the credentialing for a substitute psychiatrist. Instead of doing so, MBH promised to provide their own psychiatrist, which they never did. Patients had to find services elsewhere while the group practice waited several months to hire and credential another psychiatrist.

Even when MBH had capitated services, the capitated groups had to wait up to three months before a qualified provider became credentialed, thus preventing timely services for new patients or for current patients who were being transferred when a therapist left the practice. Another group practice reports that they have four new psychotherapists waiting to be credentialed by MBH and a waiting list of 100 patients who cannot be seen until these new therapists get credentialed.

It appears that recredentialing usually goes smoothly even though providers are required to complete extensive applications again, even if nothing has changed since their last application. However, when MBH loses the recredentialing application, it becomes exceedingly difficult to correct the problem.

On several occasions MBH has lost the recredentialing applications of psychologists, not returned their phone calls seeking information about the recredentialing process, and dropped them from their panel, causing disruption in patient treatment. Now that MBH has a monopoly in Southeastern Pennsylvania, this recredentialing problem could cause psychologists to lose their primary source of income and patients to lose their primary source of mental health treatment.¹⁰

One psychologist reported that MBH confused him with another provider with a similar name and that he was dropped from the panel. After one year, dozens of phone calls, and filling out credentialing packets three times, he still has not been reinstated.

¹⁰ Some patients may have insurance policies that reimburse for a portion of expenses for treatment from out-of-network providers or they may have the financial resources to continue to see the decertified psychologists. Other patients do not have those resources. In any event, these psychologists will not necessarily lose all of their patients. However, the abrupt financial loss may force some psychologists to discontinue their independent practices.

Another psychologist requested a recredentialing form and MBH sent her a form which she completed and returned. Two months later she was told that she submitted the wrong form and was to be removed from the panel. Several months later she was recredentialed, but she received no reimbursement for any of the MBH patients she had seen during the period that she was decedentialed.

Another psychologist received a recredentialing form that looked similar to the original credentialing form (e.g., it required verification of his degree and an internship that he completed 20 years ago), and was different from the recredentialing form that other members of his practice had recently received. When he called to request the recredentialing form, the person answering the phone insisted that he was sent the proper recredentialing form and refused to send him the correct one. There is no recourse or appeal when MBH makes such errors.

In addition, for no apparent reasons, providers will periodically learn (usually indirectly through patients or through the nonpayment of bills) that they are no longer credentialed. When this happens, patients are notified that their provider is no longer in-network, causing them to believe that they have to pay out-of-network rates. Sometimes they drop out of treatment. Even when the provider has evidence that they really are credentialed, it can take weeks or months before MBH acknowledges their credentialed status.

One group practice was recently informed that a psychologist was not in the provider network, despite the fact that she been providing services for more than two years, was reimbursed for the services she was providing, and was included in MBH's list of approved providers for that group. No reason was given as to why she was suddenly excluded from the provider panel.

Another group practice reported that their psychiatrist never received a recredentialing packet. Three months before her credentials were to expire she was informed that she would be terminated. According to the director of that group practice, when learning of this problem they immediately ensured that the recredentialing application was completed and faxed in.

Then it took 30 minutes on the phone in an attempt to confirm receipt of the application. We never got confirmation. Each time we got somebody on the phone, [we were] transferred to another department. No one seemed to know who could confirm receipt of the application.

Later, one patient was notified that this psychiatrist was longer in-network, even though the psychiatrist still had a month left under her current credentialing agreement. The situation took more than 15 hours of staff time to resolve.

These examples are representative of the problems involved. Many more examples could be provided. PPA has often tried to intervene in these situations. MBH ignores our letters and refuses to answer our phone calls.

Of course, the unilateral termination of providers without notice or cause violates the regulations of the Pennsylvania Department of Health (28 PA Code 9.722).¹¹ These providers have recourse to an appeal to the Department of Health, which could insist that the MCO uphold its contract. Nonetheless, provider groups and solo providers are reluctant to file these complaints because MBH can simply refuse to renew their contract (or give them 60 days' notice of termination), thus excluding them from virtually the entire commercial health care market in Southeastern Pennsylvania.

Other than to determine if a professional has engaged in serious misconduct (such as indicated by a founded licensing board complaint, malpractice suit, or felony conviction), we are unable to discern why the current recredentialing process is needed. If the goal is only to purge unethical providers from its provider panel, MBH could use far less cumbersome or intrusive means.¹²

Hospitalizations and Case Assistance

The XXX in-network psychologists who responded to the relevant question on the survey reported at least 56 patients who needed psychiatric hospitalizations from September 1, 2004, to January 31, 2005.¹³ These psychologists rated the helpfulness of MBH as an average of 4.2 on a 7-point scale in facilitating these hospitalizations. Several respondents noted that MBH case managers were “fast, cooperative,” or “quick, responsive.”

We do not have information concerning the perception of MBH's role from the standpoint of the hospital in terms of the adequacy of the length of stays or in discharge planning.

The rates of psychiatric hospitalizations for MBH as reported in the Pennsylvania Health Care Cost Containment Council (PHC4) report (See Appendix B) approximated the statewide average of psychiatric hospitalizations. Also, the average length of stay was slightly higher for both Aetna and Keystone products than the statewide average. Of course, PHC4 data is restricted to HMOs and not all health insurance policies.

Nonetheless, we did hear anecdotal reports that individual patients had requests for inpatient care denied, or that it was difficult to get a case manager. We are not aware of any deaths that occurred directly as a result of these delays or denials, although there were reports

¹¹ According to 28 Pa Code 9.722, “To be approved by the Department [of Health] a standard health care provider contract shall include the following consumer provisions. . . .(7) Language requiring that if the plan and the health care provider agree to include a termination without cause provision in the contract, neither party shall be permitted to terminate the contract without cause upon less than 60 days' prior written notice.”

¹² The credentialing process raises substantial public policy questions. For example, should an out-of-state entity determine on its own whether newly licensed psychologists, social workers, or professional counselors or marriage and family therapists will have the opportunity to practice in Pennsylvania?

¹³ We do not know the exact number of patients who were hospitalized because the last option in this question was 6 or more patients hospitalized. Three psychologists checked that option.

of substantial psychiatric deterioration and a burden on outpatient providers in ensuring the safety of these patients.

Upon further investigation, it appears that these denied cases should have been resolved through a formal appeal process. The issue of appeals is discussed in the next section.

Appeals

Providers expressed skepticism about the ability of the appeals process to ensure adequate patient access to care. The 2003 HMO Annual Report submitted to the Pennsylvania Department of Health contained confusing data about the appeals process.

According to the 2003 Annual HMO reports, for IBC/MBH, there were 33 first-level appeals for behavioral health care services and 0 were settled in favor of the patient. For Aetna/MBH, there were 9 first level appeals for behavioral health care services and 0 were settled in favor of the patient. This pattern of universal denials of first-level appeals contrasts with other HMOs in Pennsylvania, where patients often win first level appeals.¹⁴ However, IBC/MBH reported 176 second level appeals, 67 of which were settled in favor of the member and Aetna/MBH reported 29 second level appeals, 13 of which were settled in favor of the member. Since the second level appeal should occur after the first level appeal, it is not clear why there were more second level appeals than first level appeals.

In summary, the data submitted by MBH to the Department of Health is suspect, but there is concern that there may be a de facto policy to always deny first-level appeals.

Also, IBC's Annual HMO filing reported that only 19% of its members in 2002 knew how to file a complaint and in 2003 only 30% knew. Psychologists report that patients who call with complaints are handled on the spot (usually rejected) by the case manager and are not informed of the formal appeal process.

Other Issues

Providers reported other frustrations.¹⁵ Often the benefit information given by MBH staff is inaccurate, which makes it necessary for the provider to verify benefits at least twice or three times before getting accurate information. This is especially problematic when patients are given incorrect information about who is, or is not, an "in-network" provider.

¹⁴In contrast the 2003 Annual HMO reports to the Pennsylvania Department of Health showed that Keystone Health Plan Central, Geisinger, and First Priority had a combined total of 42 first-level appeals, 12 of which (28%) were settled in the favor of the member. They reported a combined total of 7 second-level appeals, 4 of which (57%) were settled in favor of the member.

¹⁵ If not for the harm to patient welfare and waste of resources, the bureaucratic problems would be humorous. One psychologist called a phone number with a question, was referred to a second number, where he was referred to a third number, where he was referred to the original number he called. Because he was on hold for such a long period of time, the entire process took 30 minutes. Such stories are common.

Different MBH representatives give different information. As providers who are familiar with the various plans, mental health professionals are often aware that patients have been given incorrect information, which requires the staff to call back in an attempt to verify what they already know. This information includes being told that a professional is not “in-network,” which means a higher copay. This is especially troublesome for patients who ask for a particular professional only to be incorrectly told that they are not “in-network.”

At times MBH will make appointments for patients without informing the provider group that such appointments were made. For example, one group practice reported that they received a phone call from an individual who was confirming his appointment. However, he had no appointment with the practice. Upon investigation it was learned that the individual had contacted MBH, which called the group practice and simply asked when the next non-emergency appointment was available. They did not indicate to the group practice that they wanted to book the appointment or give the name of any individual. This has happened repeatedly. Often the prospective patients calling are frustrated and angry when they learn that they were not booked for an appointment after being told by MBH that they were.

MBH sometimes directly refers patients to psychiatrists working in group practices, despite the fact that the agency requires the patient to see an intake therapist first. This is done because psychiatric time is very scarce and every effort must be made to use the time of the psychiatrist most efficiently and to use a therapist or an intake worker to gather background information. Patients feel frustrated because they did not anticipate this requirement before they could see a psychiatrist.

A patient called with a highly unique disorder outside the expertise of anyone in the group practice. The group practice spent 2 ½ hours trying to locate an appropriate professional, but was unable to do so. The MBH care manager refused to assist in identifying an appropriate provider for the patient.

These examples are representative of the problems involved. Many more examples could be provided.

Management of Medication Benefits

In 2005 Aetna/MBH determined that it will not approve certain medications, such as Zoloft, unless another medication has been tried first, even though a patient may have been on Zoloft and is benefiting from it. Sometimes the care managers are responsive to these unique patient concerns and will authorize the appropriate medications, sometimes they are not. In any event, it takes much time for the support staff, pharmacy, insurer, and psychiatrist to discuss and attempt to resolve the situation. Resolution of some problems has taken up to two weeks.

Another patient was prescribed Lexapro and was told that MBH would not authorize it. Members of the group practice, including the prescribing psychiatrist, had all called MBH

to explain the clinical necessity of this particular drug. However, non-physician personnel made the decision to deny this drug.¹⁶

Other Benefit Mismanagement

Providers will not receive reimbursement for an initial interview if the beneficiary has an uncovered diagnosis (this commonly occurs with attention deficit disorder).

One psychologist sent a TRF to MBH in November 2004. He called several times to determine the status of the request, but was unable to get any information until February 2005, when he was told that the authorization process for beneficiaries for this particular plan had to be processed differently. Ideally this would have been explained to the patient or psychologist when the authorization was first sent in November.

Also, IBC will pay for neuropsychological testing only if certain diagnoses result from the evaluation. This unusual policy discourages providers from performing neuropsychological evaluations. For most insurers, such as Medicare, reimbursement depends upon the nature of the referral. If the physicians knew the presence and nature of the neuropsychological disorder ahead of time, then they would not have made the referral for testing in the first place.

Resistance to Input

These issues have been brought to the attention of the insurers through periodic meetings (approximately every six months) between providers and MBH, e-mails, letters, or phone calls. Most of these communications have been made verbally through phone conversations or face-to-face meetings. Recently, however, we have requested that providers document their conversations or keep copies of e-mails because we want to avoid the allegation that MBH never knew of our concerns. Direct communication has not produced any improvement in the quality of patient care.¹⁷

¹⁶ Pennsylvania's Act 68 permits utilization review nurses to approve treatment decisions, but disapprovals have to be made by a psychologist (except for medications or hospitalizations) or by a physician.

¹⁷ An exception to this occurred when PPA objected to the attestation agreement that recredentialed providers had to sign. (In order to be recredentialed MBH required providers to sign an agreement stating that they would only refer patients to other MBH providers unless they had the approval of MBH; we viewed this as a violation of Pennsylvania law.) In phone conversations with MBH, they have promised to clarify their intent so that providers will not be penalized for providing accurate information to patients about their treatment needs. Since MBH and IBC have promised to resolve this issue to our satisfaction, we are not raising it in this document. Nonetheless, it appeared that MBH/IBC were going to ignore our concerns until an employee of MBH in Pittsburgh affiliated with Highmark graciously took it upon himself to intervene and ensure that our concerns were addressed. Even so, it took nine months and a threat to bring the issue before the Pennsylvania Department of Health before we received verbal assurance that our concerns would be addressed. As of the writing of this document, MBH has not yet fulfilled its promise to clarify its intent with the attestation agreement.

Cumulative Impact

These problems take their toll on patient care, health care providers, and the employers who pay for many of these insurance policies.

Impact on Patient Care

MBH gathers many statistics related to patient care, such as the average speed with which providers answer the phone or time it takes for a group to schedule an appointment. They also report having a survey in which 92.3% to 95.2% of patients expressed satisfaction with the care they received.¹⁸ It is hard to interpret MBH's patient satisfaction data as it reflects satisfaction with the treatment providers and not with MBH itself.

Theoretically MBH improves patient welfare by facilitating hospitalizations when necessary or making referrals for specialized or hard-to-find services. Also, they purport to purge provider panels of unethical or incompetent providers and they ensure that providers meet minimal standards in terms of availability to see patients in need. MBH also endorses professional guidelines from time to time.¹⁹

Nonetheless, our providers reported that many patients felt frustrated by the authorization process, disruptions in the treatment process, inaccurate information given about who is or is not in-network, misleading information on EOBs, etc.

According to PHC4, the statewide percentage of HMO patients who received mental health treatment increased from 4.2% to 4.6% from 1999 to 2001, and the nationwide percentage of HMO beneficiaries receiving mental health treatment increased from 4.3% to 5.3%. However, the percentage of Aetna/MBH and Keystone Health Plan East/MBH beneficiaries who sought mental health treatment is considerably below these state averages (See Appendix B). Of course, many factors increase utilization patterns, including the demographics of the covered population. Consequently, we cannot attribute the lower utilization only to MBH policies that discourage patients from using their benefits. However, the low utilization patterns are consistent with such an interpretation

¹⁸ The 2003 Annual HMO Report to the Pennsylvania Department of Health did not include the entire survey results, but only selected questions and response totals.

¹⁹ The very issue of endorsing guidelines is controversial. Certainly it is desirable for all providers to have their practices guided by scientific evidence. On the other hand, some groups or organizations interpret guidelines incorrectly and assume that the research always generalizes to every patient or to ignore cautionary language in guidelines that recognizes the need to individualize services based on the unique needs of the patient. We are not accusing MBH of these errors, only noting that the mere endorsement of a guideline is not without risks.

Furthermore, the patient interruptions inherent in MBH's management policies prevent providers from implementing evidence-based guidelines. No guideline recommends random interruptions in the continuity of patient care.

Financial Impact

Even when systems run smoothly, providers need to spend much of their income on support staff to do billing and other administrative chores. However, at any given time a provider runs the risk of having clean bills lost (necessitating rebilling and delay in payments or, in some cases, complete loss of the revenue for services provided), being removed from the panel (often without notice and only after bills have been denied), and having authorizations interrupt patient care. Group providers estimate that they spend about 30% to 35% of their budget on clerical and administrative staff for insurance purposes. This does not include the amount of time that providers have to be involved in the administrative details of working with MBH. Nor does the 30%-35% figure include the loss of income from uncollected clean claims. Solo practitioners, who do not have the benefit of a staff dedicated only to billing, have to spend more of their personal time on administrative details and, because of their unfamiliarity with the system, probably have a larger percentage of uncollected clean claims.

We do not know how much of the insurance premium goes toward supporting MBH's, Aetna's, or IBC's administrative structure. However, we can only present a minimum and a maximum estimate for administrative costs for outpatient mental health care. These are only estimates as the actual percentage of payment to MBH is not in the public domain. Nor do we know what percentage of the administrative costs by MBH are used for inpatient, medication management, or outpatient benefit management.

However, based on information on other managed care companies, in the minimum scenario, MBH and the primary insurers get 15% of the premium. If 30% of the providers' revenue goes toward administration, then about 38% of the total outpatient mental health care expenditures go to administration. In the maximum scenario, MBH and the primary insurers get 25% of the premium. If 35% of the providers' revenue goes toward administration, then 49% of the total outpatient mental health care expenditures go to administration.²⁰ (See Chart One).²¹ Under the maximum scenario, more than 50% of the health care insurance premiums go to administrative services.

It should be remembered that the 30-35% figure for clerical and administrative staff may be an underestimate because it does not include professional time spent on administrative

²⁰ Some IBC policies require a \$40 copay. In most cases patients are being treated by a masters degreed clinicians (social worker, masters prepared psychologist, or licensed professional counselor) who receives approximately \$60 for a 45-50 minute session. Of that fee, at least 30% is used for that clinician's administrative expenses (approximately \$18). As a result, the copay covers most of the cost of service, and the health insurance premiums contribute almost nothing to the health care service. It could be argued that the patient receives some benefit from the case management services (referrals or hospitalization facilitation). On the other hand, it could be argued that these benefits are minimal compared to the premium costs received by MBH and the treatment interruptions inherent in MBH's administrative process. The patients (or their employers) pay the insurance for the opportunity to have clinically contraindicated interruptions in the treatment.

²¹ A portion of provider revenue comes from patient copays which range from \$0 to \$40, depending on the product. We do not have access to the actual contribution of patient copays. For purposes of discussion here, we are assuming that an average of 20% of provider revenues come from patient copays.

duties nor the loss of unpaid clean claims. Furthermore, solo practitioners may have administrative costs higher than those of group practices.

It is true that some administrative expenses are inevitable. Even the most efficient health care systems spend some money for billing. Also, some administrative expenses promote patient care. Care managers will sometimes assist finding appropriate providers when patients have unusual treatment needs or when a hospitalization is needed. However, most of those expenses provide no benefit to the patients. In fact, we argue that many of these expensive administrative procedures disrupt treatment and discourage patients from using their mental health benefits.

Conclusion

Theoretically MBH ensures medical necessity through its authorization process, has a straightforward billing system, ensures standards of competence in its provider panel, assists beneficiaries in referrals and hospitalizations, and has a responsive appeal process.

This theoretical system has little resemblance to the real process. Authorizations provide no benefit to patients and discourage them from using their benefits. Even group practices with sophisticated billing staff assume that many of their clean claims will be paid only after great effort and that some will never get paid. The credentialing process is unnecessarily burdensome and, whatever benefits it has, are vitiated by its interruptions in patient care. The case management services (giving referrals and assisting in hospitalizations) are adequate, but hardly exemplary. The appeals process is highly flawed.

These issues (authorizations, credentialing, billing, and other issues) take a cumulative toll on patients and mental health providers. The effect is similar to that of erosion or littering. While one piece of trash might not desecrate otherwise beautiful scenery, the cumulative impact results in a substantial degradation of the landscape. One professional wrote that

While very hard to document or to quantify, the real issue is not really the cash flow problems or the drain on administrative resources but the stress and drain on morale of professionals who try their [best] to provide the highest possible care to clients while being beaten, abused and/or ignored by MBH. [These problems] cannot help but, at times, be subtly introduced into the clinical encounter.

In summary MBH consumes huge resources in exchange for few services to beneficiaries.

Table 3
Examples of Patient Benefits and Harm

Purported Services

Preventive

ensuring competent practitioners in-network

ensuring minimal standards of competence in the provider network (speed in answering phones, getting appointments, etc)

Direct²²

facilitating hospitalizations

making referrals

answering benefit questions

Documented Harms

Harming Patients by

delaying treatment because of delays in the authorization process

interrupting treatment because of delays in the authorization process after 8 sessions have been used, billed for, and recorded by the insurer

failing to inform providers of exceptions and changes to the authorization process in a timely manner

imposing unreasonable time limits on the authorization of services with no clinical justification

imposing restrictions on the type of therapy that can be offered (individual/family) regardless of clinical need

creating obstacles to treatment that generally discourage patients from using their health care benefits

refusing to pay for psychological testing when it is clinically indicated; or paying only for an inadequate amount of time to do the testing

Wasting Health Care Resources by

requiring a 26-digit authorization code

allowing providers to get authorizations for only 3 patients at a time

losing authorizations

failing to process their own authorizations in a timely manner

requiring providers to double-check all authorizations

sending authorizations to the wrong provider addresses, especially when providers have more than one practice location

having an authorization process that does nothing to promote patient well-being – in fact it disrupts patient treatment – and which is expensive for MBH and providers to

²² These are the purported benefits. How well MBH fulfills these obligations is another issue.

administer

Harming Patients by

- giving inaccurate information on the EOBs or authorizations
- giving incorrect information about who is or is not in-network
- failing to inform patients who are eligible for Act 150 enhanced benefits
- failing to inform patients of exemptions to their coverage
- failing to reimburse for diagnostic procedures (such as neuropsychological tests) unless certain diagnoses are made

Wasting Resources by

- changing billing processes repeatedly, thus requiring providers to invest and reinvest in new computer and software systems
- rejecting bills because of MBH errors (alleging that certain information on a form was missing when it was not missing, etc.)
- giving providers inaccurate information about billing, credentialing, or patient benefits

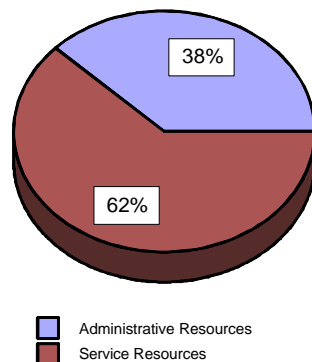
Harming Patients by

- “de-credentialing” providers without notice for prospective patients (either through delayed recredentialing, misinformation to patients, or internal record keeping error)
- “de-credentialing” providers without notice for active patients
- failing to allow for the expedited credentialing in unusual situations
- failing to implement an effective appeals process
- apparently routinely rejecting all first level appeals in an effort to discourage patients from insisting upon the benefits agreed to in their contracts
- failing to inform patients of their rights to appeal
- scheduling appointments without telling groups that an appointment has been made
- failing to approve certain drugs, even when clinically indicated and covered in the patient’s contract
- failing to be of assistance in hospitalizations or other case management situations
- failing to have physicians made the final decisions about psychotropic medications

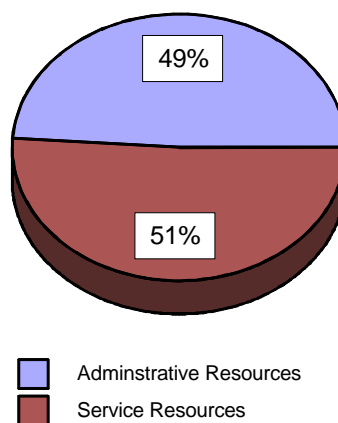
Wasting Health Care Resources by

- having a burdensome credentialing and recredentialing system
- frequently losing credentials or recredentialing packets
- failing to inform providers of their errors in the credentialing or recredentialing process

Chart One
Probable Distribution of Administrative and Service Resources²³



LOW ESTIMATE



HIGH ESTIMATE

²³For example, in the minimum scenario a patient (or employer) may pay \$100 toward health care, and 15% of that (or \$15) goes directly to administration and 85% (\$85) to providers. Providers receive the \$85 plus 20% more in patient copays or ($\$85 \times 1.2 = \102) and 30% of their revenue goes for administrative expenses (30% of \$102 or \$30.60). Therefore, of a \$100 premium and \$17 copay (\$117), \$45.60 (\$15 + \$30.60) goes for administration, or 38%.

In the maximum scenario a patient (or employer) may pay \$100 toward health care, and 25% of that (or \$25) goes directly to administration and 75% (\$75) to providers. Providers receive the \$75 plus 20% more in patient copays or ($\$75 \times 1.2 = \90) and 35% of their revenue goes for administrative expenses (35% of \$90 or \$31.50). Therefore, of a \$100 premium and \$15 copay (\$115), \$56.50 (\$25 + \$31.50) goes for administration, or 49%.

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8. In the last five months (from September 1, 2004, to January 31, 2005), how many of your patients covered by MBH of Eastern PA needed psychiatric hospitalization?

Number of Psychologists	Number of Hospitalizations
1	5
2	8
3	0
4`	3
5	2
6 or more	3

9. If you indicated 1 or more to Question 8, how would you rate the cooperation you received from MBH of Eastern PA in approving or facilitating that hospitalization?

Average rating 4.2 on a scale of 1 to 7 (1 indicating very poor and 7 indicating very good)

12. For services billed in the last five months (from September 1, 2004, to January 31, 2005), approximately for what percentage of patients did you have trouble getting claims paid by MBH of Eastern PA (for example what percentage of clean claims were paid later than 45 days after submission, etc.)?

Less than 1%	30%	1-2%	7%
2-5 %	4%	6-10 %	14%
11-20%	9%	21-50%	9%
More than 50%	11%		

13. How smoothly did MBH of Eastern PA handle your last credentialing or recredentialing ?

The survey average was 4.5 on a 7 point scale (with 1 indicating very poor and 7 indicating very good)

19. How would you rate your overall satisfaction with the services provided by MBH of Eastern PA?

The survey average was 3.5 on a 7 point scale (with 1 indicating very poor and 7 indicating very good)

Appendix B
Health Care Cost Containment Data

Health Care Cost Containment Data – 2005 (HMO/POS Combined Plans)

	Aetna	Keystone Health Plan East	State HMO Ave.	Nation HMO Ave.
Members Receiving Any Mental Health Services	4.0%	3.3%	4.7%	5.4%
Inpatient Admission Rate	3.3%	3.3%	3.5%	2.8%
Inpatient ALOS (average length of stay)	6.2	6.7	6.2	6.0

Health Care Cost Containment Data – 2004 (HMO/POS Combined Plans)

	Aetna	Keystone Health Plan East	State HMO Ave.	Nation HMO Ave.
Members Receiving Any Mental Health Services	4.3%	2.7%	4.6%	5.3%
Inpatient Admission Rate	3.6%	3.1%	3.4%	2.8%
Inpatient ALOS (average length of stay)	6.7	5.9	5.7	6.0

Health Care Cost Containment Data – 2001 (HMO/POS Combined Plans)

	Aetna	Keystone Health Plan East	State HMO Ave.	Nation HMO Ave.
Members Receiving Any Mental Health Services	2.4%	3.6%	4.2%	4.3%
Inpatient Admission Rate	3.0%	4.2%	3.6%	2.6%
Inpatient ALOS (average length of stay)	6.4	6.5	6.9	5.7

Appendix B (continued)

References

Pennsylvania Health Care Cost Containment Council. (2005, March). *Measuring the Quality of Pennsylvania's Commercial HMOs*. Harrisburg, PA: Health Care Cost Containment Council

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Note: The 2005 report used data from the Calendar Year 2003. The 2004 report used data from the Calendar Year 2002. The 2001 report used data from the Calendar Year 1999.

Both Aetna and Keystone Health Plan East used MBH as the behavioral health care subcontractor in 1999 and 2002, the years covering the data in this report.