

## Survey suggests partnering relationships will improve

*Alan Adkins, MD*

Access can be defined as timely patient contact with appropriate providers of needed health services. Timely contact facilitates early diagnosis and treatment. Appropriate providers mean culturally competent practitioners with necessary clinical skills. Needed health services should result in improving the health status of the population being served. Access is centrally important because it correlates with quality of care and health outcomes.

In Wisconsin, as in most states, the majority of care for mental health and substance abuse disorders is provided on an outpatient basis. Accordingly, access to mental health and substance abuse providers in the outpatient setting is extremely important; minimizing barriers to access is essential.

The article by Kinderman et al that appears in this issue addresses a spring 2003 study conducted by the Division of Health Care Financing of the Department of Health and Family Services (DHFS), which represented a movement from anecdotal

concerns to a more data-driven focus. This clinician survey focused on the providers' perspective of obtaining authorization from HMOs or gatekeepers and how significant a barrier the authorization process was for them. Over the years, there have been many cost-sharing strategies where the focus has been on the demand side (requiring that patients assume more of the cost of the services). However, pre-authorization affects the supply side of the equation (whereby providers typically request additional authorizations once those initially granted are exhausted). This is the issue addressed in the DHFS survey.

The survey results were straightforward and entirely consistent with member and provider satisfaction survey data from a large Medicaid HMO in Wisconsin. Many Medicaid providers continue to transition from the former fee for service environment. The DHFS study indicated that many (22%) providers forgo requesting additional services they deem necessary because they believe the requests will be denied. Furthermore, 28% overstate patient needs in order to get approval. The Kinderman article summarizes these results, and notes that

while the survey results were generally positive, there is still room for improvement in the mental health services referral process.

An abundantly clear message from the survey data is that there remains a golden opportunity for health plans to educate and partner with mental health and substance abuse clinicians servicing the Medicaid population. Health plans have an obligation to provide their membership with highly skilled, culturally competent and available clinicians who can serve as patient advocates when necessary. Health plans also are responsible for continuously monitoring their network of practitioners around quality measures including clinical practice guideline compliance, complaints, service indicators, and so on.

As the managed Medicaid marketplace continues to mature, the expectation is that innovative approaches to partnering with high-quality provider groups will become more commonplace in Wisconsin. With increasing data, provider profiling will become more of a reality, and the resulting decrease in administrative requirements will serve to establish more of an equilibrium on the demand side of the health care equation.

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Doctor Adkins is corporate medical director at Cenpatco Behavioral Health, which is headquartered in Texas. Cenpatco contracts with Managed Health Services to provide behavioral health services to people in central and southeastern Wisconsin.