Special Report

As State Redesigns Medicaid, Outer Cape Presents Special Needs and Fears That Will Test the System

By Laura J. MacKay
Provincetown Bureau Chief

The radical reform underway of the Massachusetts Medicaid system, designed to cut costs and improve care, will narrow health care options for recipients.

While those who scrutinize the prospects of the new system disagree on its potential effects, the Outer Cape with its combination of special needs and insufficient resources will be a crucible for measuring the two-year experiment to reform the way government provides health care to the needy.

State officials and many health care providers hail the changes, saying they will enable — even force — Medicaid recipients who previously fell through the cracks to get personalized care. But some watchdog groups fear the new restrictions could sacrifice quality for cost-effectiveness.

An additional concern for the new system is its ability to provide care for those in need of sophisticated treatment and for chronic problems.

The presence in this area, for instance, of a population requiring treatment for AIDS-related problems will probably test the capabilities of the reform program, which has been propelled by the Weld Administration since the state legislature a year ago received approval from the federal government to cut the "budget-busting" Medicaid costs, now more than $3 billion a year, by changing from a fee-for-service to a managed care system.

Called MassHealth Managed Care, the program is certainly not the first, but will be the largest of its kind in the country. Savings to the state, taking into account anticipated increases under the old system, are projected at $88 million over the two years for which the state received the waiver from the federal government to change the system.

The idea, in essence, is to funnel Medicaid patients to locally based generalists or clinics for basic and preventive care, and for direction to specialists, as deemed necessary. A goal is to reduce haphazard use of medical services, such as expensive emergency room treatment for routine problems, and to identify and treat ailments before they become critical (and costly).

Until the new system, the state's 620,000 Medicaid recipients were free to seek treatment from any provider — physician, hospital or clinic — that agreed to take Medicaid patients.

Although expensive and inefficient, such a system gave patients with chronic and complex problems — like AIDS — flexibility to find treatment suited to their needs. This is especially true on Cape Cod where medical resources are not concentrated.

Now, Medicaid recipients will be assigned to a single, locally based general practitioner or health maintenance organization (HMO) to serve as "gatekeeper." As with managed-care programs under private insurers, which are increasingly becoming the preferred options by employers and individuals because they cost less than unrestricted insurance, the primary physician authorizes referrals to specialists.

At least 40 states have or are developing some form of managed care within their Medicaid programs, according to a report by the federal Health Care Financing Administration. But few are as comprehensive as Massachusetts', which also includes more tightly managed care for substance abuse and mental health problems.

A 1991 study by the National Academy for State Health Policy, a private, non-profit think-tank on health reform issues in Portland, Me., gave good grades to the managed care system of the 11 states studied.

But no program of its kind is as big as the Bay State's. About 420,000, or 68 percent, of the state's Medicaid recipients are expected to come under the managed care mandate, including some 9,300 on the Cape and Islands.

Maryland takes a distant second with plans to enroll about 227,000.

Consequently, the Massachusetts experience is being closely watched. As Scott Penn, director of Outer Cape Health Services in Provincetown, said: "If Weld can make this work, he'll be a superstar."

Adds Trish Riley, of the Maine study group, "Massachusetts is certainly a leader — they've learned from the mistakes of other states — and they've made a commitment to managed care."

Initial enrollment, as is now happening here, can be a problematic process, said Ms. Riley. But, ultimately, "there is no evidence to indicate managed care provides less quality service than fee-for-service," the traditional means, she said. Managed care systems, as she pointed out, are examined for higher standards, because they are supposed to be more accountable, inasmuch as they are "managed," as opposed to the previous ad hoc treatment/payment system.

Much of the outcome, say students of the health-care delivery system, including Ms. Riley, depends on how the program, under the aegis of the state Department of Public Welfare, is administered.

The department has hired a private company, Foundation Health Federal Services, Inc., in Boston, to run the system, using health benefits managers stationed in every welfare department office. These managers advise recipients on regulations concerning matters such as enrollment, physician assignments and disputes over referrals or other medical decisions.

Some people are automatically exempt from the pro-

(Continued on Page 11)

Medicaid -Continued

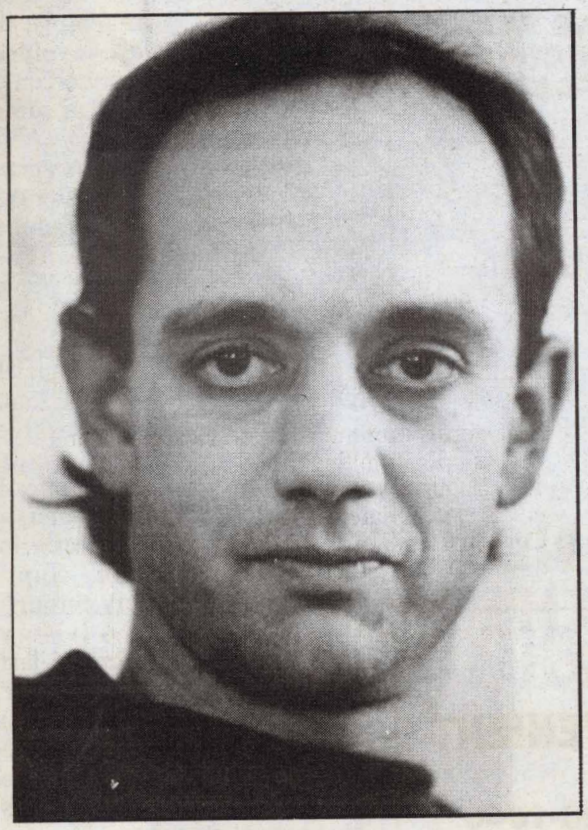
gram, including those who are over 65, have other insurance, or are institutionalized.

But a problem is already anticipated, as enrollment, due to be completed by the end of February, progresses, if recipients seek exemption from the managed care because they believe no doctor in their area can meet their needs.

To date, only 450 of the 250,000 people enrolled have asked to be exempt from the managed care, according to the welfare department, but the most problematic cases are yet to come.

According to state figures, more than 50,000 of the enrollees will come from the category classified as disabled, such as many AIDS patients and people with spinal cord injuries, among others. This group is being signed up last because of special problems identified with their treatment, for instance the need for chronic, or highly specialized, expensive care.

This is the trouble spot some consumer advocates foresee. "You've just added another layer of bureaucracy to fight through," said William Henning, director of the Cape Organization for Rights of the Disabled. "That can be a problem if you have an acute medical condition."



"Another layer of bureaucracy to fight through can be a problem if you have an acute medical condition."

--William Henning

Geography is a factor that some fear will hamper patients from getting the best care. Established doctor-patient relationship might be disrupted because someone "lives on the wrong side of a geographic line," maintained Neil Cronin, who follows health care issues for the Massachusetts Law Reform Institute in Boston.

Although the program is still in its formative stages, Mr. Cronin, for one, said he believed the standard applied by the state regarding exemptions, for reasons like objections to the proximity advisory, "seem to be fairly rigid," although neither he nor employees at several other legal-service organizations could supply supporting data.

The state, which reimburses patients for travel, has instructed doctors to refer Medicaid patients "to the geographically closest appropriate Medicaid provider able to provide the required services." But, said Jeremiah Cole of the state welfare department, this is a consideration, not a restriction.

By forcing Medicaid patients to form a relationship with a primary doctor, MassHealth will promote indi-

(Continued on Page 25)

"We think we can make it a win-win situation, a way of building a better partnership with our patients.."

--Scott Penn