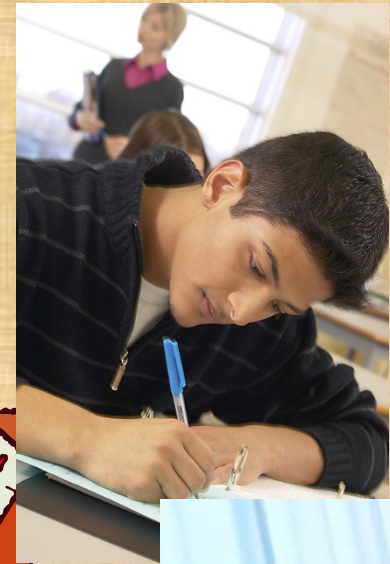
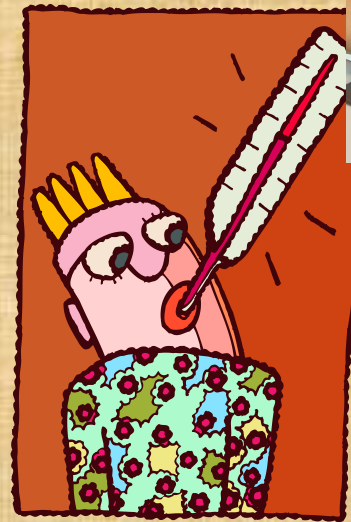


Welcome to Course 2C!

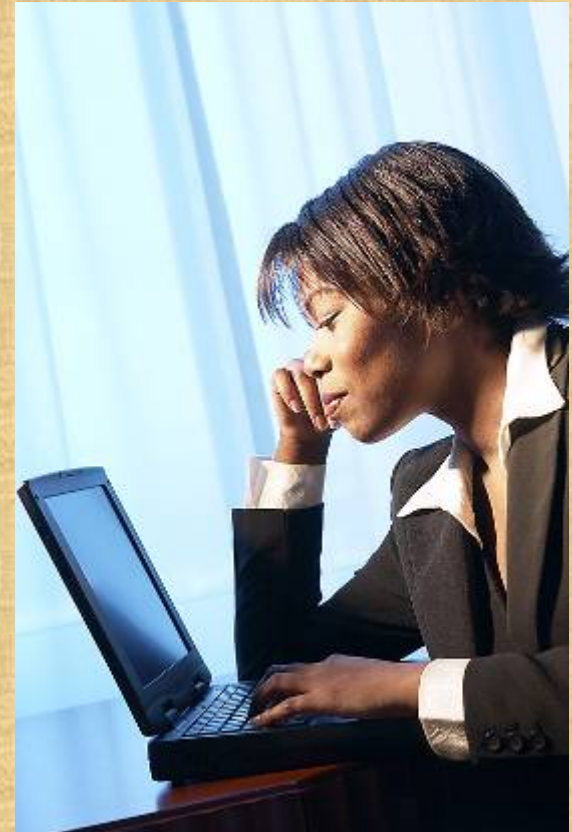
Professional &
Clinical Issues In
Managed Care –

Necessary Shifts
in Program Design
and Treatment
Approach



Part A of Lesson 1, Course 2C

Understanding How MCOs Think, and How To Deal With It.





What Are the Primary Goals of Managed Care?

- **Control the rising cost of healthcare, a.k.a. COST CONTAINMENT**
- **Improve consumers' access to services through expansion of programmatic offerings**
- **Promote healthy competition among providers**
- **Offer consumers a broader choice of providers**
- **Improve quality of care**
- **Promote innovation in delivery of services**
- **Improve outcomes for consumers**
- **Yes! *Control the cost* of healthcare!**



OK – but WHY are they doing this?


What are they REALLY trying to accomplish with Cost Containment?

Trying to accomplish . . .

The designers of the new public sector managed care plan need to be clear about what they are trying to accomplish, in terms of **COST CONTAINMENT**. What are they trying to do, exactly? Are they trying to . . .



 **REDUCE FUTURE** spending *below* current spending? Hopefully not! Most treatment systems are under-funded already.

 **KEEP** the amount that they are spending **NOW**, but hold the line there? Like, a **NO GROWTH (NO INCREASE)** budget in the coming years? Really? No growth. . . ever?

 **SLOW** the budget's growth in a responsible way, and utilize the current budget **MORE EFFECTIVELY?** Now that sounds better! We can do this!

Cost Containment . . . Is it always good? MAYBE! It depends on how they do it!

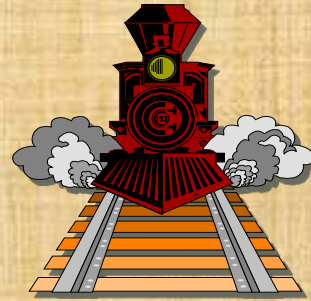
The immediate goals of the State's contract designers can have a tremendous impact on the success of the new plan. Some goals are good, some are not.

- **An up-front REDUCTION in the State's CURRENT behavioral health budget is likely to NEGATIVELY AFFECT quality.**
- **In fact, quality will probably suffer if the State cuts back the amount of money that it CURRENTLY spends on healthcare!**



Regardless of what you have heard, Managed Care is NOT the solution to a grossly under-funded behavioral health care system!

Diversification . . . and other cautions!



- Providers are wise to diversify their source of income (their 'funding base') because 'putting all our eggs in one basket' is dangerous. This is especially true for those who have always relied upon block-grant type contracts, which are decreasing or going away as managed care moves into states.
- For state governments: They need to 'go slow, go slow, go slow'. Haste can be damaging and counterproductive, when they move into RISK BASED Managed Care contracts too fast. (We talk more about RISK BASED contracts in Courses 1C and 5B, and FlexiCourses 4A and 5A.)
- For the fearful: We cannot stop the 'managed care train', although 'some routes may be discontinued' as states experiment with various designs of managed care. Some designs are better than others! **And NEW DESIGNS are coming!**

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Rev 2006, 2010, April 2015**



You Need to Know About the Impact of the Affordable Care Act (ACA) Upon Providers, Including Some Entirely New Twists That Are Likely Coming.



Yes, you heard correctly. Coverage for everyone. No matter how sick they are. At a reduced cost.

When the Affordable Care Act (ACA) was passed in 2010, the idea was to REDUCE the COST of ALL types of health care, and AT THE SAME TIME, to ensure that uninsured individuals became insured, *regardless of their 'pre-existing conditions.* Treatment to the entire US Population was to be paid for – at a significantly *reduced cost.*

The ACA ...

To support the Affordable Care Act, the Federal Government and some States have put into place an array of contracted healthcare insurance companies and other such organizations (referred to as 'The Marketplace' or 'Health Insurance Exchange') to assume the responsibility of providing comprehensive health care at a significantly reduced cost.

The Marketplace's Health Insurance Exchange Companies then contract with selected provider networks to deliver the care at a reduced cost.

To reduce the cost of care, the 'Marketplace' or 'Exchange' companies must contract with a LIMITED NUMBER of providers – particularly NETWORKS of providers – who are willing to deliver care at a reduced rate of reimbursement . . . with the emphasis being upon QUALITY, OUTCOMES, and 'VALUE-BASED' (rather than upon a 'fee-for-service' model where 'more' is better for the provider).

Value-Based? What's That?

It means an emphasis upon 'Value – NOT Volume'.

- **It means employing *evidence-based* approaches and *proven* treatments and techniques,**
- **as well as *expected outcomes* – in deciding on a treatment intervention, and**
- **taking into account the *patients' wishes and preferences, and the cost of the care.***

In other words, you don't simply have a 'standard list' of treatments and interventions that you employ for every person with a particular diagnosis.

A focus of health reform in hospitals has been to more closely track 'value' measures such as complications, hospital-acquired infections, and readmissions. Hospitals now face financial penalties if their rate of readmissions is too high, for example.

In *behavioral health*, we would track complications and adverse incidents, admissions or re-admissions to more intensive levels of care, ability to work if appropriate, ability to live independently if appropriate, medication compliance, results of drug usage screens, rate of appointments kept, and so forth.

Limited Networks. Is this a new concept? No, it's not.

Is limiting the number of networks a new concept? And contracting for specific outcomes? No. Some states (such as Texas, Oregon and several others) have been doing this in Medicaid behavioral health for more than 20 years. Now it's simply ramping up!

Naylor & Associates (now CEU By Net – Pendragon Associates, LLC) began working with Medicaid Managed Care Companies (HMOs, MCOs, and BHOs) *and* with behavioral health providers in 1992 about these issues. The idea was to ensure that NETWORKS and comprehensive care agencies delivered cost effective treatment under a 'Care Management**' scenario.**

Care Management?

Care Management is designed to ensure that the care that is delivered and paid for actually WORKS . . . at a CONTROLLED REIMBURSEMENT rate.



Under this arrangement, the care that you provide to your client is reviewed and approved on an ongoing basis by a 'Care Manager'. And rather than being paid for each instance of service provided to your client, your payments were oftentimes 'bundled' - aka, paid according to a 'case rate'. A 'case rate' is a type of 'flat rate' plan. Like, payment per week of treatment. Or per month. Or per 'episode of care.'



This shift in delivery of care resulted in FEWER contracts with individual providers and small agencies, and MORE contracts with NETWORKS of providers and larger agencies – both of which agreed to provide COMPREHENSIVE CARE. It was the beginning of today’s ‘NARROW NETWORKS’, referred to in those days as ‘PREFERRED PROVIDER NETWORKS’.

Is this a good thing?

Such arrangements bring about many good things – including ‘wrap around’ services, intensive case management of recidivistic clients, more day and evening Intensive Outpatient Programs, 24-hour observation units, reduced waiting lists, and so forth.

Outcomes have differed, however, depending upon the State and the design of the plan. NOTE: Although not ‘new’, in some states this movement is *just now beginning, with the advent of the ACA.*

So What Is Different with the Arrival of ACA, Compared to Prior Initiatives?

For one thing, enrollment in an insurance plan is mandated for all, to avoid a Federal tax penalty. This inherently means many more people to serve, despite a fluctuating funding base.

Therefore, the use of 'NARROW NETWORKS' is becoming the norm in most states, to reduce ACA cost. Further, it is clear that the ACA is moving toward 'VERTICAL INTEGRATION OF CARE'.

VERTICAL INTEGRATION OF CARE? WHAT IS THAT?

It means that the insurance companies which are taking on more (and sicker) patients would like to move to a NEW form of BUNDLED PAYMENTS. In these new scenarios, ALL care would be coordinated and provided to individuals under *one provider umbrella*, so to speak. And in this situation, VALUE-BASED PAYMENTS would be SHARED among all providers who deal with a patient's total health condition, WITHIN A 'HEALTH HOME' or 'Medical Home'.

Vertical Integration of Care Would Mean 'What' for Mental Health and AOD Providers?

- **In a sense, this could be a step backward for mental health and addiction providers who worked hard to bring about the “Behavioral Health Carve-Outs” for Medicaid. The carve-outs ensured that behavioral health would receive dedicated funds in the Medicaid budget, separate from physical health. In fact, AOD providers wanted (but did not always get) separate funds apart from the mental health side.**

The current planning calls for a Primary Care Physician to serve as the gatekeeper for all care which a patient receives, including behavioral health. Many question whether the behavioral health issues would receive needed attention.



Anything Good About Vertical Integration of Health Care?



It is fairly well recognized on both sides of the healthcare fence (physical health and behavioral health) that many treatment situations are sorely lacking in integration between the two areas.

Examples in support of vertical integration:

For example, an individual may have one or more *medical problems* that exacerbate his or her use of drugs and/or alcohol, but the AOD treatment provider is unaware of the medical issues. Or, the PCP may prescribe medication for insomnia but is unaware of both the client's *SUD issues* and of other medications the client may be taking to reduce the use of substances. From this perspective, integration of health care is a good thing.

So How Will This Work – for Behavioral Health?

It's unclear at this point exactly HOW this will work with a person who has significant medical (physical) conditions AND also has a Substance Use Disorder (SUD) and/or a mental health disorder. Some pilot projects at the State and National level are in the first stages of implementation, seeking the best way to VERTICALLY INTEGRATE care for the physical, behavioral and social aspects of health care.

To what extent these pilot programs integrate AOD and Mental Health treatment with physical health treatment has not yet been demonstrated.



- **However, the very concept of INTEGRATION OF CARE speaks directly to the need for behavioral health providers to begin thinking 'NETWORK'. And 'SERVICE COORDINATION'. And 'FLEXIBILITY' in service design. And working with NEW PARTNERS. And OUTCOMES!**

'OK. But . . . They're Changing Up So Much of What We Do – and How We Do It. Is that really necessary?'

Well, yes, they are. Those who hold the behavioral health funds (public or private) are making some serious changes in how they spend the money. And even the commercial insurance carriers are following suit. But WHY do they have to change how we deliver care?

The reason is an even greater need for 'Cost Containment' under the ACA. And 'Cost Containment' has always brought concerns.

Concerns About The 'Cost Control' Element

With the coming of Managed Care to several states, a decade ago the National Alliance for the Mentally Ill (NAMI) expressed concerns that the emphasis would be placed upon the element of COST CONTROLS instead of upon the element of CARE. And of course, the State legislatures typically ARE most concerned about the element of COST, as their primary reason for implementing a managed care model.

NAMI's concerns were first clearly expressed in 'Grading the States 2006: A Report on America's Health Care System for Serious Mental Illness.' An example is this statement (and similar statements since then) in their 2006 *Report Cards of the States*:: "Managed care models sometimes turn into *managed cost models*."

Concerns of NAMI . . .

And further, NAMI has reflected the thought that managed care companies' corporate emphasis upon *profit* could result in harm to the delivery system [and this would apply to Mental Health and to CD-AOD.]

For example, one comment made in the 2006 report is that too often " people's needs are sacrificed in favor of private profit incentives." That concern *has not changed*, in terms of how NAMI and many other behavioral health advocates see the potential problems.

However, the Principles of the Affordable Care Act Have the Support of NAMI.

Says NAMI on its website:

“The Patient Protection and Accountable Care Act (ACA) addresses many of the challenges people have in getting and keeping health care coverage. [There are] key provisions of the law that offer meaningful benefits to individuals living with mental illness and their families.

NAMI identifies the following ‘Patient Protection’ provisions of the ACA as particularly positive for persons with mental health and addiction disorders:


- **Pre-existing Medical Conditions – care cannot be denied based upon such.**
- **Extension of Dependent Coverage**
- **Prohibits lifetime limits**
- **Prohibits annual limits for certain types of plans**




A CD Issue Related to Care Management Decisions


Special Note: Standardized Level of Care protocols (such as those typically used by the HMOs, BHOs, MCOs) are believed by many to result in questionable clinical outcomes for chemically dependent consumers. Reason: These protocols may not adequately accommodate the CD population's inherent tendency to relapse repeatedly while they are on the road to recovery. What to do here? Encourage your state and MCO to engage in good Quality Management studies of outcomes for CD patients – and sufficient FUNDING! And for your most relapse-prone clients – especially those who recycling in and out of detox frequently – ask for a 'Case Rate', where you can make treatment decisions more freely – where you 'hold the cards'.

What IS clear now, it that even more rigorous management of treatment authorizations will have to be done.

 **The money placed in the care of MCOs and other such managed care companies has always been limited – but now, with the ACA and its expanded population and mandates, the funds are effectively even MORE limited.**

 **In other words, despite the expanded mandates, the MCOs must still **PRIORITIZE** who gets treatment, and what they get, and for how long!**

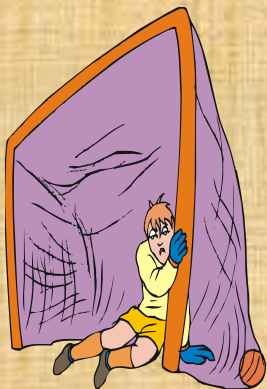


 **HOW DO THEY DO THIS?**

IT'S STILL CALLED CARE MANAGEMENT!

The 'at risk' entity (MCO or other) MUST carefully CONTROL AND MANAGE the use of the various services that are available to the enrollees (members)! IF they don't MANAGE AND LIMIT THE CARE that is delivered by providers, they will lose a great deal of money by the end of the year. That's why they call it 'Managed Care'.

This is one of the hardest things for providers to deal with in managed care. Why? Because they must give up their control, in determining what treatment their clients receive.



You will learn about the 'Four Core Concepts' that drive the MCO's Care Management decisions, in Part B of this Lesson 1, and some pointers on documentation in treatment records. (Note: In Course 2B, we go into greater detail about documentation in records, to fully mesh with these Four Concepts.)



Hold On To Your Thermometer!

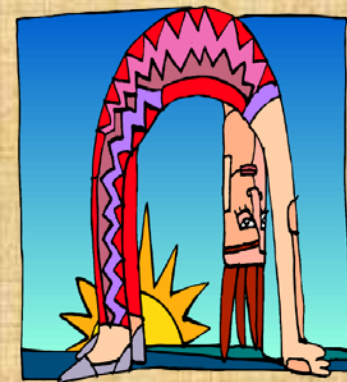
OK . . . but in general, how does Care Management (or Utilization Review) work? Providers no longer have the freedom to deliver care 'at will' – at least not if they want to be paid for the care they deliver. There is a need to obtain PRE-AUTHORIZATION (pre-approval by the MCO or other Managed Care Company) to deliver services to the consumer, if you want to be paid for the service.

The MCO will authorize ONLY the care that is ABSOLUTELY NECESSARY – i.e., only the care that is 'medically necessary'. They decide if the patient is 'sick enough' to receive a certain treatment, and if so, for how long. There are also such factors as 'is he making any progress?' that come into play here. More on that in coming material.



Summary Statement: For mental health consumers, MCOs DO NOT look simply at whether or not it would be 'helpful' or 'nice' for the individual to have a certain type of treatment, or whether the patient simply 'wants it'. And they DO NOT base decisions upon a plea that 'we have always done it this way.' Many of the 'old ways' have been discarded or radically modified, in this day of 'short funds' and more rigorous management of treatment. Who gets treatment has also changed.

For the CD client, MCOs DO NOT look simply at whether or not he or she is having an alcohol or drug related crisis, or whether or not he has experienced a recent relapse, in order to say 'OK' to a treatment request. And they DO NOT base decisions upon a plea that 'we have always done it this way.' In fact, if the client has had multiple relapses to use of alcohol or drugs despite treatment, they may begin to question whether additional treatment beyond detox and basic services is really justified. Here too, who gets treatment has changed.



- **IMPORTANT NOTE:** Is the managed care company telling you that you **CANNOT** provide the services which you believe the client needs? **NO.** A provider is *always* free to deliver any service to a patient according to the provider's own professional judgment or organizational philosophy. **HOWEVER** – if the managed care company does not feel that the services are **MEDICALLY NECESSARY** and **ESSENTIAL** for the stabilization of the patient (or if the health plan simply does not cover a certain service or limits how much can be provided), then you **WILL NOT BE PAID** by the managed care company to provide the service. You will have to do it for free ('pro bono'), or will have to use other funds to cover the cost.

Beyond Care Management, what other ways do MCOs use to contain costs?

The next slides reflect some of the other Cost Containment methods that we are seeing around the country, in Behavioral Health Managed Care.



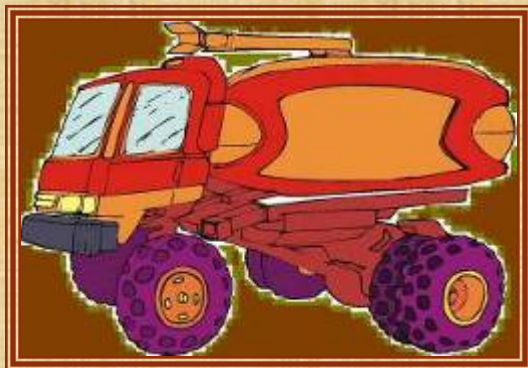
The shift to Managed Care includes new-style financial arrangements – which can be challenging.

↳ There are **NEW CONTRACT FORMATS** (bye-bye unconstrained General Revenue and Block Grant – and in many states, it's now hello Fee-For-Service). This is prompting providers to seek new, additional funding streams so that they can be financially secure. All eggs in one basket is still not a good idea!

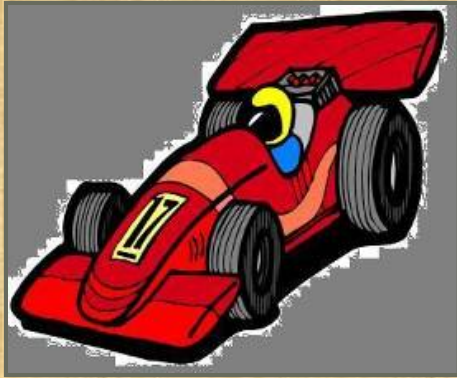


↳ What is different about **FUNDING DECISIONS**, i.e., who gets the Provider Contract?

With the coming of the ACA, it's now an even more competitive field, with newer, **BIGGER** providers coming into the mix – and ultimately, the Provider Agreements will almost certainly be awarded to the providers with **BETTER OUTCOMES**.



So where are the States and the Feds moving 'to', with the Provider Agreements? They are almost exclusively moving toward FEE-FOR-SERVICE FUNDING MODELS (i.e., you get only the money that you EARN, one session at a time) instead of fixed annual contracts. With Fee-For-Service, there is NO 'regular monthly check' coming in the door. This is a major part of the COST CONTAINMENT strategy.



**And what else? The States and the
Feds are moving toward cost-saving
Managed Care contracts with 'Big
Business' – such as large Managed
Care Organizations (MCOs), or similar
arrangements with large provider
groups – who will provide or arrange
ALL of the treatment that patients
receive . . . perhaps both the
PHYSICAL care AND the mental
health and addiction treatment.
(Remember Vertical Integration, and
the Medical Home?)**

- **Many new providers are now **COMPETING** for the business – and many will get it, instead of the ‘traditional providers’ getting most of the business up front through State grants and contracts.**



And – most significant of all - the MCOs are shifting where and how the money is spent!

- **In managed care programs, the MCOs CAN SHIFT where the funds are currently being spent – and they can oftentimes do it with better outcomes! This is one of the best features of managed care.**
- **How does this work? The MCO can *shift* some of the planned expenditures from one type of service to another, to avoid unnecessary over-usage of certain services . . . such as shifting funds FROM State Hospitals and other costly services, TO highly effective rehabilitation programs in the community. And development of 'step-down' services in the community shorten inpatient stays as well as prevent unnecessary admissions to high-level services. That is GOOD for community providers, and for clients!**



Yes, MCOs are looking for new community services providers, as part of this Cost Containment effort. New to the system, or here for 30 years – there is no preference here. It's whoever will do the job, and do it well.



The MCOs are moving away from the historical idea that providers 'can provide whatever they are comfortable with, and it will meet all the needs.' Instead – in order to CONTROL COSTS (i.e., 'cost containment') – the managed care MCOs want to see a FULL ARRAY of services out there in the delivery system . . .

. . . even if they have to force the issue through bringing in new providers from out of state to deliver the services that are needed.



In short, providers must move 'out of the box' (or further out of the box) to survive – and the MCOs must move out, too!

Because of the new competitive and creative provider market, traditional providers and private practitioners must 'move out of the box or die'.

AND this is true even for MCOs, who must adjust THEIR business, too.

- **For example: Many MCOs have been serving traditional commercial insurance enrollees only. But to participate in the public sector managed care business, they must NOW serve the indigent, and persons with MAJOR BEHAVIORAL HEALTH DISORDERS (including persons with severe mental health and chemical dependency issues).**

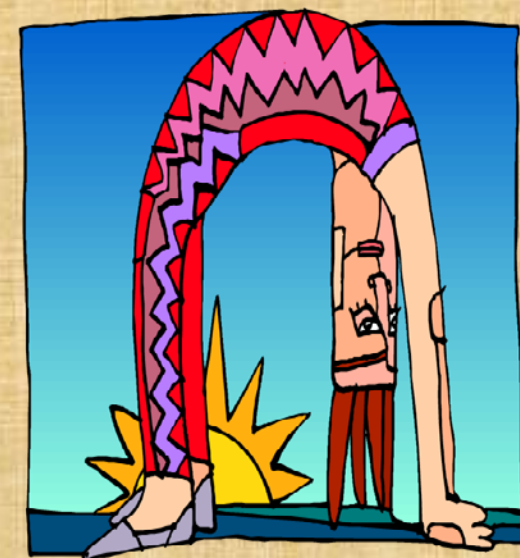
Because of the populations that the MCOs must now serve in greater numbers under the ACA, they have no choice but to offer more **SPECIALIZED** services to meet the needs of severely impaired individuals. These specialized services will reduce the need for more expensive services.



For example, they will ensure that there are services which will **DIVERT** patients from **UNNECESSARY** admission to the more costly levels of inpatient care – i.e., there must be intensive home based services, detox units, Intensive Outpatient Programs, intensive case management, and so forth. Offering such '**DIVERSIONARY**' and '**STEP-DOWN**' services is one way that the managed care company can **CONTROL** its **COSTS** (i.e., its expenses).

Clearly, the managed care company's decisions may contradict a provider's own CLINICAL BELIEFS about 'how much' of 'what' is needed at any given point in time. For example, the managed care company will probably limit how long an individual remains at the more expensive levels of care. How? The MCO may 'step them down' to a lower level of care (less intensive and less expensive) long before the provider (in the past) would have done so. Is this really 'bad'? Not necessarily. It may just be 'different', PROVIDED THAT EFFECTIVE ALTERNATIVE PROGRAMS are available through the MCO's coverage.

Providers are encouraged to be flexible in providing and using alternative step-down programs for their clients.



There ARE effective alternatives to traditional treatment!

📁 **Even if the provider is opposed to the MCO's practice of 'stepping the consumer down' to lower levels of care, it is important that he be willing to work with the ALTERNATIVE APPROACHES TO TREATMENT which are promoted by many managed care companies and will likely be made available within the network.**

📁 **Over the past few years, programs have been re-designed with good results. Some of the best emphasize community based treatment alternatives focus upon TEACHING SKILLS to effectively deal with symptoms and to live and work successfully within the community. Even in 'commercial' managed care plans, long term 'talk therapies' have given way to a briefer COGNITIVE AND BEHAVIORAL approach to anxiety and depression, instead of insight therapy.**





Such alternative treatments have a place in Managed Care now – even if they were not previously allowed under the rules for ‘regular’ Medicaid!

In order to reduce the use of inpatient treatment and its huge cost, most Medicaid Managed Care plans DO allow (and even emphasize) innovative, ALTERNATIVE SERVICES – stuff that is truly ‘outside the box’ (e.g., ‘non-traditional’ treatments such as out-of-office, in-home-and-school programs, and other community-based treatments). When such programs are fully implemented, we know that they often work BETTER and perhaps FASTER than the traditional approaches.

NOTE: In many places across the country, these programs have been in full swing for years – BUT such alternatives MAY NOT HAVE BEEN ALLOWED for ‘regular Medicaid’. Under Risk Based Managed Care, however, an MCO typically has the freedom to use alternative services, where it was not possible before.⁴⁷

The MCOs' freedom to use diversionary and step-down programs when they are managing a 'Risk Based' Medicaid Program is a clear indication that providers should be ready to rise to the occasion in the delivery of such programs – even if the call does not come until the new Managed Care plan has been in place for a few months.



NOTE: Many providers have been doing this type of diversionary service for a long time – but probably not for an MCO! So, it's time to expand these programs! In any successful managed care plan, these services are eventually needed – if the MCO is responsible for paying for Inpatient Treatment as part of it's RISK arrangement.

But how do these services get worked into the Provider's contract with the MCO?

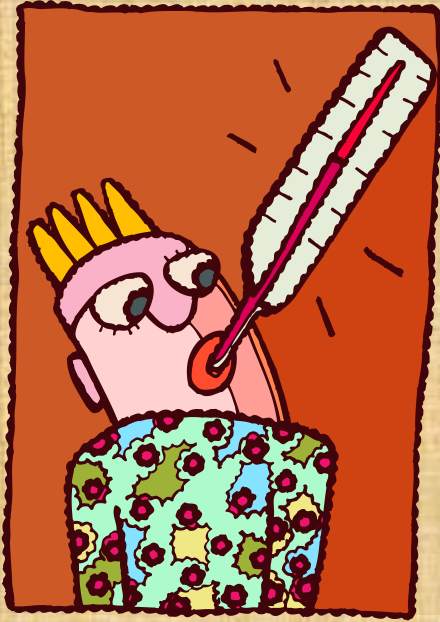


Specialized services such as these are oftentimes NOT brought into the picture UNTIL the new managed care plan has been in place for a few weeks or months. The MCO may want to first see what is needed. In Course 1C we address 'The Good, The Bad, and The Ugly' in managed care contracts – including some creative ways for providers to deliver services to clients under a managed care model, maximizing innovation, flexibility and autonomy in delivery of services.

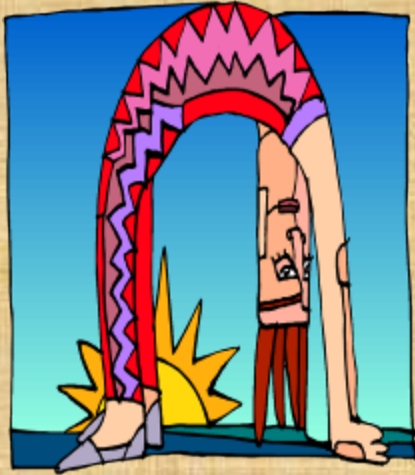
Flexibility In Programs – It Can Be Painful to Some.

Under Managed Care, program design does take some new twists that are unfamiliar to some professionals and Boards of Directors. Like what? Programs such as Intensive In-Home Services, out-of-office service delivery . . . true 24 hour availability and the need to extend telephonic response to 'around the clock' . Some Boards of Directors are fearful of the inherent legal liability of out-of-office services. And we also see new requirements that can be irksome . . . such as the need to pass through some sort of external Utilization Review (UR – or Care Management) to obtain permission to treat . . . having to play 'Mother May I?' with the MCO. These are major issues to the uninitiated.





**But is the
news ALL
BAD? No.**



COMMUNITY PROVIDERS can support this new way of spending funds by ‘thinking outside of the box’ – whether we are a private practitioner, or a State Hospital, or a not-for-profit agency, or a Substance Abuse provider network, or a CMHC or Mental Health Clinic! Flexibility and innovation are **IN!**

- Providers can re-design and/or enhance the services that they provide – in order to ensure that creative, non-traditional services are available. These services will help the managed care company to **PREVENT UNNECESSARY** admission of patients to the most expensive levels of care. And it can be **GOOD** for consumers, too!



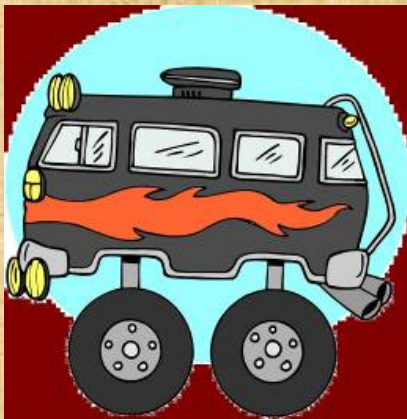
What's the reward if you decide to 'play the managed care game'? Those providers who are willing to 'think outside the box' – creatively – may get a major share of the business from the MCOs! This is one thing that makes contracting with MCOs so interesting – it's a whole new ball game! Traditional providers no longer have a 'lock on the business'.



Yes, there is a critical need for providers to diversify and modify their CURRENT SERVICES, to meet the new managed care needs.

Diversify Your Funding Stream!

But remember . . . even those providers who join the shift to managed care need to diversify (expand) their funding sources to include non-managed care funding! Don't put all your eggs in one basket – even if you have a good contract with an MCO! Consider doing some Employee Assistance Program (EAP) contracts with self-insured companies – in the USA and in other countries.





Now . . . how to survive all this change, from a clinical perspective?

We'll take a look at the some of the most pressing clinical issues in Part B of Lesson 1, Course 2C





Congratulations!

You have completed Part A of Lesson 1 of Course 2C. You may complete the short quiz for this section now or later. If you wish to do so now, simply close this page, and click on Quiz 1, Course 2C.

You can take each quiz as many times as you want, until you pass it. There is no penalty for failing a test and you may retake it immediately.

To move on to Part B of Lesson 1, either close this page now and click on Part B of Lesson 1 (Course 2C) or return later to the site, sign in to your My Home Page, and click where you want to go!