



Lesson 2 - Course 2C

This relatively short lesson (the final lesson in Course 2C) focuses primarily upon how providers can collaborate to achieve new goals, and looks at some of the internal operational issues and challenges associated with Managed Care.

This is the last lesson in this course!



Q: Is this course and this module actually relevant for those of us who are in private practice or private organizations?

A: YES. In most states, Managed Care [in which authorization for treatment is governed by some type of 'Care Management' pre-approval or treatment authorization process] is coming on strong, due to the shrinking funds available to behavioral and rehabilitative health. This movement affects both the traditional public sector providers and the private sector providers.



And why is this?

It is important to know that the very same principles that guide managed care companies (MCOs) in the treatment approval process ALSO now guide commercial insurance carriers such as Aetna, Blue Cross Blue Shield, and others . . . when it comes to approving or disapproving your requests for behavioral health treatment for your clients and patients.

If you are on a commercial insurance ‘provider panel’, you will find that – as the demand to reduce healthcare costs increases – the vigorous use of ‘pre-approval’ and ‘continued stay’ criteria will also increase.

And so yes, this course applies to individuals working in the private sector as much as it applies to those working in the local CMHC or Substance Abuse Treatment Center³.

A bit of history about how private practitioners and organizations became involved in this managed care movement . . .

- **HMOs, MCOs, commercial insurance carriers (like Blue Cross Blue Shield, Aetna, and others who include behavioral health and rehabilitative treatment in their benefits schedule) -- and even State-managed Medicaid Plans -- now utilize the services of the private sector as much (and oftentimes more) than they utilize the local MHMR Centers and other State agencies. This may not be true in your state at this point in time - but that's the direction that most States are moving.**

- **The reason for this is that many private sector providers were initially less set in their ways than providers in the traditional government-funded Community Service Programs . . .**

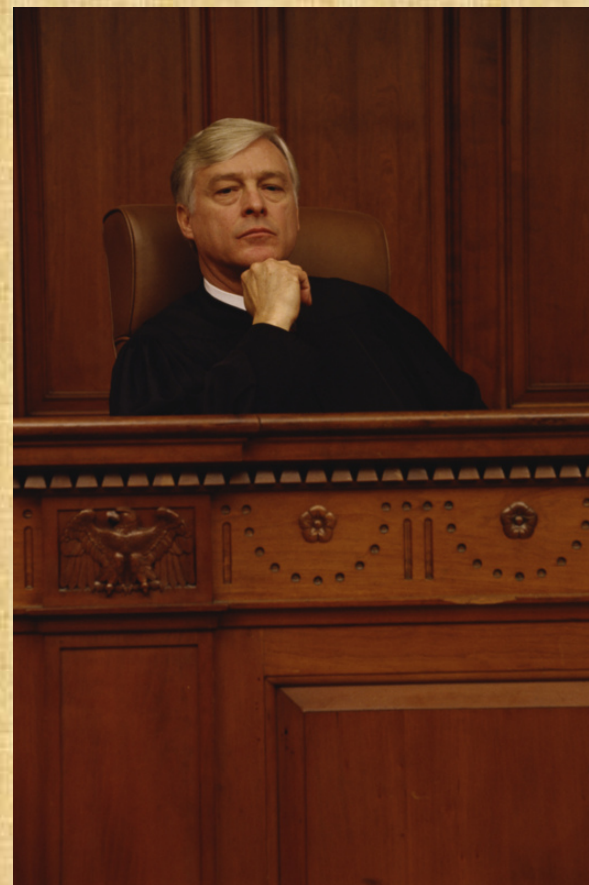


- **. . . and thus those who wanted a piece of the new revenue source (managed care contracts) tended to be more creative and flexible in striking cost effective contracts for innovative services. At least initially.**

- **Furthermore, in most states, traditional Medicaid providers had become accustomed to automatic annual contracts . . . whereas private sector providers are used to working for every penny they get (a.k.a. Fee For Service)**
- **And thus the private sector was perceived as easier to work with (according to most HMOs, MCOs, and other Care Management-oriented insurance companies).**
- **Granted, there were and are some private practice trade organizations that continue to fight Managed Behavioral Health Care - but the number of such instances is waning.**

- **But the private sector DID NOT AUTOMATICALLY grab a bulk of the business in every state. Why not? When Medicaid funding went into a managed care mode across the country, the TRADITIONAL PUBLIC SECTOR PROVIDERS within the Community Service agencies made an effort to ensure that they would be the ONLY organizations to get these new 'public money' contracts. AND some States supported the Traditional Providers in this bid for exclusively and claims of 'imminent domain'.**

- **But the Federal Government eventually said NO to such bias in favor of the Traditional Providers - opening the gate to enterprising private provider organizations and private practices to grab a share of the business.**



But now there are partnerships!

Most progressive public sector providers have now entered into the movement with gusto, to ensure their survival. Many of them now partner extensively with the private sector, to deliver cost-effective treatment with good outcomes – much to the delight of the managed care companies (whose main concern is that those services are delivered – one way or another). And with the plans involved in expansion of the Affordable Care Act, there may be new kinds of partnerships – even between Primary Care Physicians (Medical Homes) and behavioral health providers.



If managed care has not come on strong in your state yet, it likely will – especially with the advent of the ACA. Some understanding of how it all works - and of the opportunities that are available to the private sector through interesting contracts – can be helpful to private practitioners and private organizations, in states that are on the verge of making this type of a shift in how treatment and rehabilitation is delivered.

**But even without
Medicaid Managed
Care or the Affordable
Care Act in a state . . .**



**. . . as the pressure on the
commercial insurance
companies increases – to
REDUCE PREMIUMS AND
THE COST OF HEALTH
CARE – we are going to see
an increase in the pressure
placed on ALL providers to
use effective and
innovative services,
sometimes at reduced
rates, but in increased
volume.**

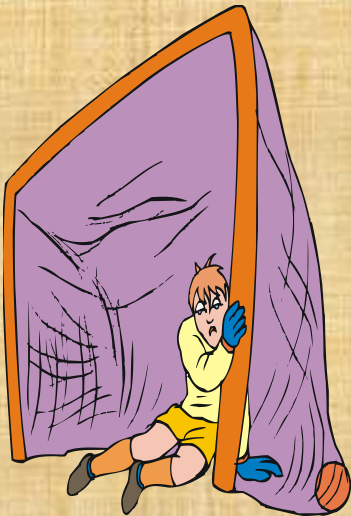
It's a new day in health care planning, service delivery, and funding! And this means changes in the workplace as well as in the treatment records.

MANAGED CARE is not your 'same old' health care system. Or your 'same old' practitioner or health care employee! Not your 'same old' program environment, either. Whether in private practice or program operation, providers must find ways to work Managed Care into their operations. And they must also gain some LEVERAGE within a managed care environment. Some shifts may need to occur in who provides services, who directs services, who sits on Boards of Directors, and with whom we partner. Some will seek out new partners to fill in the gaps in services, and some providers may choose to leave the scene entirely.



As we said in the previous lesson . . . providers, States, *and* the HMOs must alter how they usually operate and think.

- **For anyone involved in healthcare: Productivity, outcomes, and cost effectiveness are the new watchwords – ‘doing good’ is no longer enough.**
- **For all providers: We must not ignore the potential impact of the shift to managed healthcare. ‘Resting on our traditional laurels’ – in terms of how we deliver services and how we obtain our funding – places agencies and private practices in an extremely vulnerable situation.**



And providers must move 'out of the box' to survive.

There is opportunity knocking here, for willing providers!



Many providers have been doing this type of service for a long time – but maybe not for an MCO! If so, it's time to expand! And sometimes it is easier to expand and adapt if you coordinate with others who are in the same boat.

Networks are important!



**Of great importance is this fact:
There is no need to swim in
these unfamiliar waters alone.
There is comfort and safety in
coming out of isolation,
collaborating with other
behavioral health providers in
ways that were unheard of 5
years ago, in order to 'survive
managed care' in style!**

Provider Networks and Strategic Partnerships – A Winner Under Managed Care

- **PROVIDER NETWORKS:** Providers *working together* – a workable ‘ticket’ to surviving the shifts in the Behavioral Health industry. A way to gain ‘collective leverage’ and facilitate productive Provider Agreements with managed care companies. A way to cope with the managed care phenomenon with less pain and more gain. [Some call it ‘safety in numbers’! Others call it ‘rising to the occasion’!]



Network Coordination and Collaboration Has Many Advantages – Such As Leverage and Stability.



- Enables *coordinated* negotiation and discussion with the managed care company about problematic aspects of Provider Agreements. Although no joint fee-setting talks are allowed, there CAN be joint discussion of such things as problematic contract language and unrealistic outcomes expectations.
- Collaborative discussion with the HMO may also result in higher rates for specialized services due to the bargaining power of a group of diverse specialty providers. Leverage, leverage, leverage!

Leverage, Stability AND Special Roles!

Remember the increased move to 'narrow networks' within the ACA, discussed in a previous lesson? It's best to start NOW, to ensure that your organization is not squeezed out.



Multiple network agencies and individual practitioners working together as a 'provider consortium' or 'provider advisory council' can also lead to designation of the network participants by the HMO as 'Core Providers' – or 'Specialty Providers' – for Seriously Emotionally Disturbed (SED) children or Severely Mentally Ill (SMI) adults, or for Chemically Dependent adults or adolescents. May also lead to improved rates for specialty providers, for specialized services!

Network Collaboration Advantages . . . More Business Options!



Network collaboration – and strategic coordination among competent practitioners – undeniably brings in new visibility and new business within the community, for all concerned. Why? Because there is a fresh perception of network participants, a change-up of the way that the community views you, and thus improved referral relationships. Also, working outside of an isolated box tends to bring about enhanced professionalism for all – because we tend to sweep the cobwebs out of the corners when we become more visible!

Specialization. Interagency collaboration and creative partnerships may also make it possible to consolidate or centralize the provision of some specialized services within the network – making use of the *unique talents* of the individual agencies or practitioners within the network. Examples: A medication clinic may be offered by *one* agency or practice for the clients of *several* agencies; specialty services for dual diagnosis MH/CD clients may be offered by one or two network providers for the entire network; a walk-in urgent care clinic may be offered at one or two strategic locations instead of at all agency locations; IOP for MH and CD/SA adults and adolescents may be offered by a couple of network providers for the entire network ; detox may be offered by one specialty provider, eating disorder treatment by another, etc.

Advantages

Retention of clients: Making good use of the unique talents of individual agencies in a network also makes it possible for practitioners and agencies to retain difficult clients when a higher level of care is *temporarily* needed . . . rather than to lose them outright to another provider when the client requires 'something more' than what you provide. How does this work? With responsible coordination agreements in place, clients may be referred to 'step-up' services within the network during a crisis, to a provider who offers short-term step-up services – things like detox, 23 hour observation, short term residential units, and rehabilitative day treatment. When the crisis is past, the client returns 'home' to your practice or agency.



Advantages . . .



Optimizing Resources. With

strategic alliances and agreements in place between providers, we may also be able to consider certain program shifts or expansions that seemed impossible before, without the support of a collaborative partner. You can OPTIMIZE your own resources and efforts. Like, you might off-load or downsize certain low-volume services by referring that piece to a network partner, so that you can focus on starting that Intensive Outpatient Program (IOP) that you have been wanting to start.

Advantages . . .

- ***Efficiency and Cost Management.***
Everyone does not have to do ***everything!*** Explore centralized and coordinated performance of some crucial clinical services – such as centralized 24/7 telephone triage which can be ‘purchased’ by several network agencies or practitioners, from one network agency or practitioner who can more easily perform this after-hours task. This makes impossible tasks do-able . . . collectively.



Advantages . . .

Alliances also are a ready-made source of referrals of clients who need your specialized care – network partners refer among themselves.





***So is this
'partnership' stuff
a bed of roses?***

Well . . . no.



So let's take a look at some of the potential barriers and challenges that accompany network collaboration.



Anticipated Barriers to Network Coordination

It has its challenges! Like what?

- **Senior staff and board leadership – or practice partners – who don't want to give up power and control through a strategic collaboration or expanded partnership**
- **Fear of needing to come 'out of the box' – clinging to 'tradition.'**
- **Fear of losing 'the gold' through forming a partnership or collaboration with others, having to share clients and contracts**



Anticipated Barriers, cont. . . .

- **Paranoia – jealousy – mistrust of motives of other agencies**
- **Suspicion of other partners' pursuit of their own goals, in addition to network goals**
- **Fear of being out-done by network partners or collaborators – losing the limelight in a particular niche of service delivery**



Anticipated Barriers, cont. . . .



- **Less productive partners:**

Resentment can fester when one or more network partners fails to 'do its share' in regard to assigned tasks or shared activities.

New Partnerships Prompt Innovative Links Between Unlikely Parties

- Two or more State agencies as partners
- For-profit MCOs partnering with trade associations (CMHCs) and other not-for-profit providers and 'private provider' networks
- CD/SA education and prevention providers, partnering with CD/SA treatment providers – how often did you see THAT, in the past?
- Not-for-profit agencies partnering with other not-for-profits, and perhaps even with for-profits – forming provider managed networks
- Advocacy groups partnering with treatment



**But make
sure that
your ethics
MATCH!**

The Rules of Strategic Partnering and Agency Collaboration

- **Expect and give commitment to each other's well being – and this goes beyond avoidance of professional pirating of clients. True strategic partnerships are stronger than interagency coordination.**



Choose partners or collaborators for more than politics – do you 'fit'? Do you share a common set of ethics? If not, friction will dilute your effectiveness.

The Rules . . .



- **Formalize all decision making techniques – no ‘off the cuff’ decisions allowed – include review & modification workgroups.**
- **Formalize the ‘rules’ of partnership, such as ‘it’s fine to pursue a contract on your own – but just tell us about it up front.’**
- **Forget courtesy ‘on-paper-only’ collaborations which have no real function. It’s meaningless, and is eventually seen for what it is by the community and contractors.**

This is sounding a lot like Big Business. Is that what we are saying here? Yes.

- **Prompts strategic partnerships between providers, and even between providers and MCOs**

↳ **just like big business!**

- **Has survivors and quitters**

↳ **just like big business!**

- **Comes out of the box to compete and stay viable**

↳ **just like big business!**



The time is now!

- **Move from 'Mom & Pop non-profit' to a corporate management philosophy**
- **Secure strategic alliances - merge & grow**
- **Capture a corner of the market - become a "niche" leader**
 - **Focus Board of Directors upon leadership, vision, and strategic thinking – versus operations**
 - **Prepare for a potential need to change Board composition, and even internal management**

**Think Like the
'Big Guys' at
Google.
Amazon.
Microsoft.
Apple.**



In other words, if you are not already 'there', become a business!



- **Learn to recognize where CD and SA practices are ripe for “business-ization”**

↳ **Recognize that your survival depends upon it, and make a decision about survival**

- **Start to think like Amazon; allow yourself to say “If this was Amazon, would I do it this way?”**

↳ **New Business Thinking has a place in your organization, and is the key to survival in the new age!**

Re-Design . . .



And don't buy the old mantra that says that behavioral health providers should be limited to 18-20 hours of face-to-face (billable) intervention, weekly. This is perhaps one of the major hurdles we encounter with 'old guard' agency clinicians, when we must switch from the 'regular monthly check' from the State or other fixed contracts, to a 'fee-for-services-delivered' system. NOTE: Private practitioners have long ago dispelled the notion that providers will 'burn out' with more than 20 direct service hours. However, consider compensating program staff for increased productivity through workplace flexibility and incentive programs.

AND WHAT ABOUT PROGRAMS? Remember those basic shifts in program design that we discussed, earlier in this course?

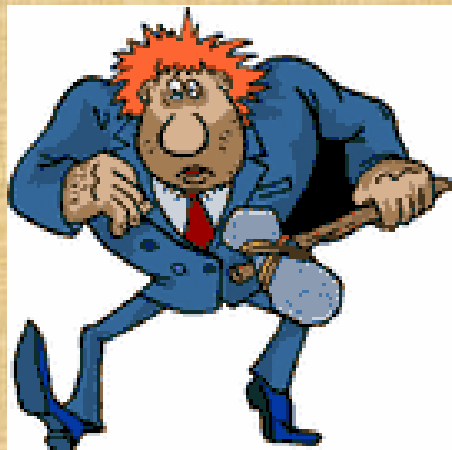
What new 'out-of-the-box' programmatic shifts are worth considering in your practice or program, in order to be successful in managed care? This depends in part upon . . .

- the provider's own professional biases and beliefs.**
- the 'culture' of the provider's agency or practice (e.g., flexibility vs. rigidity, play-it-safe vs. trying a new direction).**



Are you and your co-workers willing to examine current beliefs about treatment, and about documentation in client records? Open to new ideas that managed care brings to the front? Like in-home and in-school Intensive Home Based interventions?

Flexibility! How do you help co-workers and employees to set some of their historical beliefs about delivery of treatment on the back burner?

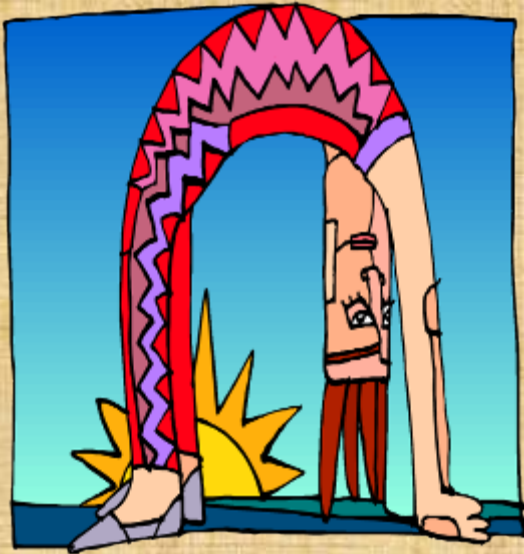


*Stone age thinking
leads to stone age
clinical
performance!*

A change-up of the entire program's or practice's historical approach to programming and treatment may be **CRUCIAL, if your organization is to compete and grow in this new healthcare environment.**

Even for those programs and practices which have moved beyond 'old guard' programming, there may be some surprises in store in terms of new twists in managed care – although many of you may actually teach the HMO a thing or two!


Flexibility is important because MCOs make daily decisions about WHICH treatment and HOW MUCH of that treatment is 'Medically Necessary' for enrollees – AND LIKE WE SAID, THESE DECISIONS MAY CONTRADICT HOW TREATMENT HAS ALWAYS BEEN PROVIDED. This is particularly true for Chemical Dependency services and for treatment of persons with less-than-severe Mental Health disorders (such as non-psychotic depressive episodes and anxiety disorders) – who may receive limited treatment after assessment.



Special CD note, once again . . . Standardized Level of Care protocols (such as those typically used by the HMOs, BHO, 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 HMO to engage in good Quality Management studies of outcomes for CD patients! 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'. Check out Course 3B for CD Treatment Providers!

All of which brings adjustment issues in the workplace, which must be resolved.

Like conflicts in . . .

- Perspectives
 - Priorities
 - Values
 - Image
 - Corporate Culture
- 
- Conflict of perspectives between 'old guard' and 'new system' staff – it may be a 'traditions' thing.
 - Introduction of managed care 'bottom-line oriented' culture – management and line staff may see money and budgets differently.
 - Increased emphasis on 'image', credentials, and professional presentation – a 'values' and 'priorities' thing. 41

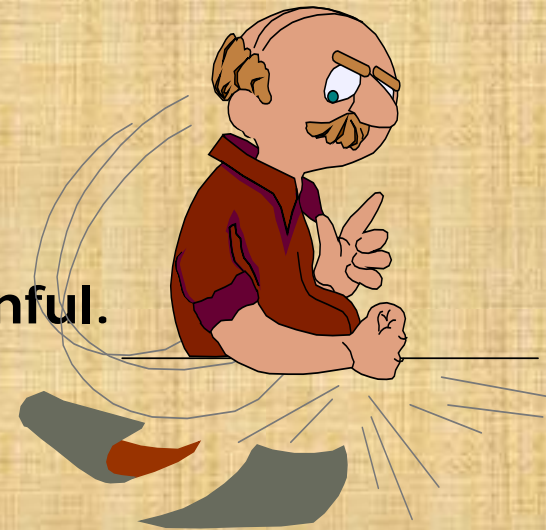
(Re)Training, Culling, New Hiring Practices . . .



(Re)Training, culling, and some new hiring approaches are often necessary in agencies and group practices, in order to get the right staff who can rise to the occasion. And, Board of Director education is critical in not-for-profit agencies and networks!

Human Services Programs Are Often Led by People With Passion

- **Recognize the biases**
- **Build on the strengths**
- **Be open to new ideas, even if initially painful.**
- **Balance passion with good management**
- **Practice good recovery principles from a MANAGEMENT point of view. Recognize that not everything will be accomplished in one day, but that consistency and ultimate attention to your reality situation is CRITICAL TO PROGRAMMATIC OR PRACTICE SURVIVAL.**



**It's a new day.
Rise to the
occasion.**



Congratulations!

You have completed Course 2C. You must now pass Quiz 3 for Course 2C.

You must pass all 3 quizzes for this course, and must complete our short Feedback form for the course, to receive your CE Credits. You will then automatically receive your 'instant download' certificate for this course, on line. Save it. Print it. Even email it to yourself.

To reach the links for the quizzes and the feedback form for this course, simply close this page, and follow the links to your quizzes. Or to come back later, just log in to your My Home Page and click the link to the course.

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