

Lesson Two Of Module 101

**Overview of
Managed Care
Concepts and
Implications,
continued . . .**

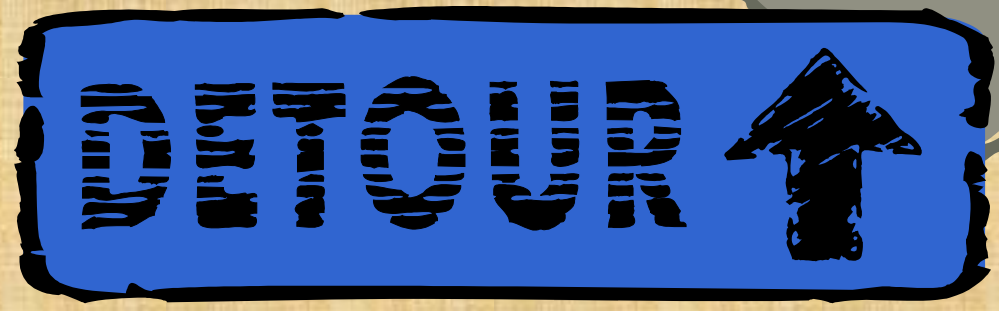
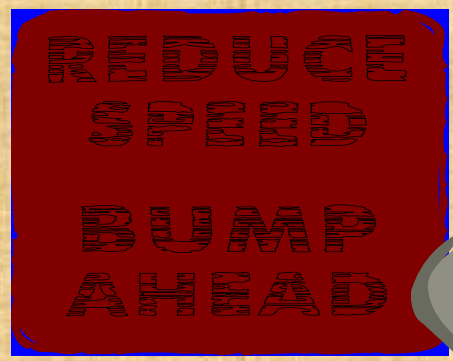


**This is the 3rd
Study Guide for
Module 101.**



**Eleven 'Weak Links'
Which Cause Major
Problems In
Conversion to
Managed Care**

The Problems, Issues, and Pitfalls





11 'Weak Links' Which Cause Major Problems in Conversion to Managed Care

In this lesson, we will address each of the following eleven 'weak links' in turn:



Divergent readiness, biases, and goals of the various participants (the Feds, the State, the HMO, the provider, advocates, and consumers)






Implementation on the ultra-fast track



Too little historical data – actuarial, encounter, and actual cost-of-services

Weak Links . . .



-  **Inadequate funding all the way around**
-  **Overblown expectations – a function of the ‘wish list’ or misconceptions of advocates, the State and legislators**
-  **Poorly designed contractual details – at the contract procurement stage (‘Request For Proposals’ or RFP) and at the time of contract signing – including sketchy programmatic design, and vague or half-baked contractual requirements related to outcomes**

Weak Links . . .



Data problems (huge issue for States and the HMOs!)



Claims payment problems (huge issue for providers!)



Inadequate funding of State Office operations



Many lessons to be learned about 'cultural sensitivity' and 'access'



Failure of parts of the delivery system to "get on board the train"

#1 Divergent Readiness, Biases, and Goals

→ 1st Weak Link



Not all managed care participants are 'on the same page', and not all are truly ready for this shift! Who are we talking about?

- State and Federal Agencies
- Providers
- Legislators
- Advocates
- Consumers
- HMOs, BHOs, MCOs



State and Federal Agencies

- **Mission driven and dedicated to build and change**
- **Seizing opportunities to fix what is wrong in the system**

But also . . .

- **Too hurried, too harried, trusting too much**
- **May have myopic vision of required details, and thus may not provide necessary information to bidders**
- **May have an unclear view of the programmatic details, and thus these evolve 'on the fly' *after* the contract is signed – major problems here!**
 - **May not maintain effective control of the managed care company or other such contractor**



Providers

- **Grand case of denial ('it will go away'). A common but deadly belief. It won't go away.**
- **Some programs and practices will not survive – especially if the Feds and/or the State moves too fast.**
- **Some will prevail through creativity and 'leaving the box' in how they deliver care.**
- **Some will seize cooperative partnerships with the HMOs, and thereby will secure their niche (and perhaps special rates).**



But some will wait too long to get in the swim with others – there is safety in numbers!

Legislators

- Swept up in the 'new wave', may move too fast
- May abdicate or delegate too much in terms of design, on the promise of cost savings
- May naively focus on the bottom line without understanding how you get there . . . what you must 'give' to 'get'
- May become alarmed '*after the fact*' – this sets up derailing of a project that is already going, perhaps after much of the current system or 'safety net' has been dismantled.



MH and CD Advocates

1st Weak Link
Divergent Readiness, Bias, Goals



- Too much time writing letters and e-mails?
'Get visible'! Attend all public hearings and
'town hall' meetings, and sign up at the
door to speak.
- Need to talk **'constructive reality'** to HMOs /
BHOs and government . . . not sob stories.
Call. Meet.
- Need to become savvy re systems change
issues.
- Need to focus upon **'slowing the train'** or
'designing the travel route', instead of upon
stopping it.

1st Weak Link

Divergent Readiness, Bias, Goals

Consumers

- **May be left out of the official 'input' loop except as 'tokens', without special consideration.**
- **CAN work effectively with advocates and providers to shape the system . . . and thus can assume much 'derived power' through strong partnerships.**
- **Need to develop an active Consumer Advisory Council and get it approved by the State to function actively as the plan rolls out.**



HMOs, BHOs, MCOs

1st Weak Link
Divergent Readiness, Bias, Goals

- **They want to do well – success sustains the business. But the Feds, or the State or the contract or the process may inadvertently set them up to fail.**
- **They, too, need to ‘come out of the box’ and become creative, in how to serve persons with major mental disorders, and in how to involve both ‘old’ and ‘new’ providers. This takes time to evolve.**



HMOs . . .



- **Some are taking on too much at one time. The HMO or BHO may be doing 'too much business' elsewhere so that they cannot function well in new contract rollouts. Their internal claims and other systems may 'max out'.**
- **Some write great RFP responses, but are in reality the 'wizards behind the curtain'.**

- True 'pilots' should precede any major rollout of a new managed care plan.
- Inadequate time for planning at the Federal, State and/or Contractor level spells trouble. Must move to managed care carefully.
- Must have true 'readiness review' of 'The Marketplace' – the HMOs, BHOs, MCOs website administrators, and other such entities that will handle the business – are they still rushing about to put things in place at the eleventh hour? Are they actually ready?

#2 Implementation On the Ultra-Fast Track





Ultra-Fast Track . . .

Stakeholders are crucial to success!



- **Inadequate involvement of the stakeholders up front is a Big Mistake – very common in the ‘Ultra Fast Track’ approach.**
- **‘Too fast’ sets the stage for a public sector backlash.**

#3 Little Meaningful Historical Data . . . means no sound basis for cost, actuarial, or encounter projections!

**'INADEQUATE OR WRONG
historical data' – the product
of guesswork or baseless
prediction – means that there
WILL NOT BE a sound basis
for budgeting, contracting, or
bidding. When this is the
case, it may result in . . .**



Little Meaningful Historical Data . . .

- **The Feds and the States jumping into an expanded level of managed care without enough information to give the bidders, about the true cost of services or how many people will likely show up for services.**
- **unwary MCO applicants bidding on a 'pig in a poke'**
- **the Feds, State and stakeholders having unrealistic expectations of HMO contractors who win the bid**
- **MCOs finding that there is NOT ENOUGH money to do a good job, because the Fed's and State's predictions were wrong.**



Little Meaningful Historical Data – The Numbers Are Still Oftentimes ‘Off’, Despite Computers



A ‘Timeless’ Example?

“An Overwhelming Demand. [Maryland] State officials acknowledge they bungled the launch of privatization in 1997. They had predicted they would need \$1 million in the first year, assuming 40,000 patients would turn up for treatment. They were wrong. The number of patients that year was close to 80,000. The accompanying bills topped \$5 million. ‘Initially, we were overwhelmed,’ said Oscar Morgan, director of the Mental Hygiene Administration.”

– *Matthew Mosk, Washington Post Staff Writer
February 12, 2001, Page A01*



#4 Inadequate Funding

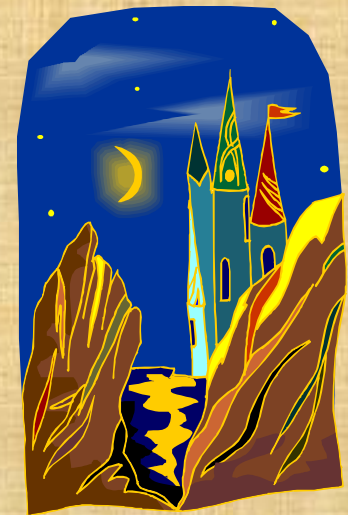


- Inadequate pre-managed care funding for behavioral health generally means inadequate funding for the new pilot. Managed Care will not result in magical expansion of resources.
- Across the board budget reductions as we enter a new, untested pilot = likely failure of the pilot.
- Unrealistic *contractual demands* vis-à-vis the available funds to do the job = anger, disappointment, frustration, derailment.



#5 Overblown Expectations

- **Unrealistic expectations and fantasies about what will be accomplished in the first few months = anger, disappointment, frustration, anger at the HMO, derailment of what can be a constructive process.**
- **'Wish lists' may shape the expectations of most everyone regarding the covered benefits . . . but the money may not support it, and the contract may not require it.**



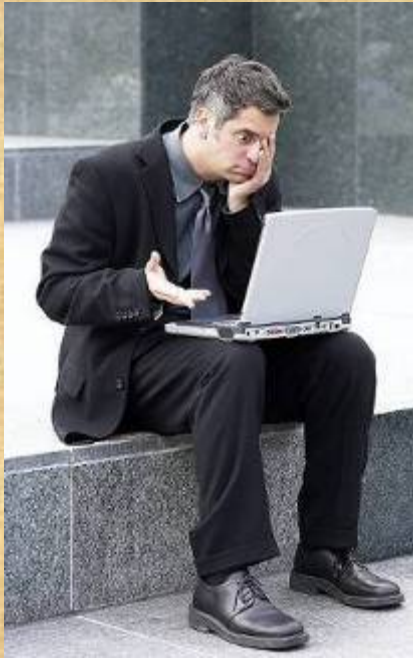
Overblown Expectations . . .

- **False belief among legislators that this will be 'so much cheaper' = a lack of understanding about what managed care does. Managed care is primarily for *controlling cost increases* AND shifting the way that we spend the money – *NOT reducing the overall budget* (at least initially).**





#6 Poorly Designed Contract Details, In the State's Contract with the Feds and the MCOs



- If there are NO (or vague) expectations about the percentage of enrollees who should be served, then we may see a LOW 'PENETRATION RATE' (a low percent of the total enrolled population will actually come to the door for services).
- If there are NO (or vague) mandates for 'WHICH specialized services *MUST* BE PROVIDED', then we may see an INADEQUATE array of program services – an array which does not meet the needs of special populations (such as persons with major mental disorders and persons with Chemical Dependency issues).

- **'Lack of details' = 'lack of clarity on all sides', including performance expectations for providers and for the MCO itself. This will result in a contract that is HARD TO ENFORCE, and a tendency to develop requirements 'on the fly' (on the spur of the moment). May lead to unnecessary failure of the plan, and considerable stress between the providers and the managed care company.**



#7 Data-Base Issues, a.k.a., Is the Program Working?



The only way to **KNOW** if the managed care program is **'WORKING'** , is through collection of the **RIGHT DATA**. **BUT** data woes are likely if there are . . .



- **Voluminous data requirements (THIS IS NOT GOOD!) – we do not want to gather data on every conceivable thing. We should collect only the data which will tell us if the program is working or not. Too much data chokes the data gathering system, so that all we may see is 'data meltdown'.**

- **Wrong or irrelevant data gathered (not good either). Yes, this actually happens. We may know everything *except* "Did it work?"**

- **Un-timely data analysis – such as twice yearly data analysis and reports – in which case the data is too old at the time it is analyzed and published to do anything with it. That is, it is too late to spot and interrupt developing problems in the system.**



- ***What we really need from data:* A 'report card' for both the managed care company *and* the providers that tells us 'did it work?' Without this, The stage is set for a public sector backlash, i.e., "You see? We knew this would not work!"**



#8 Claims Payment Problems

The claims payment systems of commercial managed care companies are *oftentimes not well suited* to the huge volume of claims payments that are inherent in public sector managed care programs like Medicaid. Therefore, the systems become overwhelmed and bottlenecked. Another timeless example:

“The state spent \$8.3 million to hire Columbia-based Maryland Health Partners -- later swallowed up by Magellan Health Services Inc. -- to evaluate each claim and pay the providers. But the company ‘couldn’t handle that volume,’ said its president, Damian Briggs. . . . From 1997 to 1999, an auditor found, Maryland Health Partners sent out \$138 million in payments past the 30-day deadline. Half were more than 60 days late. An additional \$148 million in claim denials was also late, giving providers little time to appeal.”

**Matthew Mosk, Washington Post Staff Writer –
February 12, 2001, Page A-01**

Claims problems like these result in . . .

- frantic efforts by managed care companies to overhaul commercial claims payment systems so that they can handle the huge volume and new contracts.
- claims payment systems stalled – providers frantic and cash poor!
- anger among providers, fury at the HMO, and some providers unable to cope with uncertain cash flow – which may result in loss of some good providers.



Claims Payment Problems . . .

Federal HIPAA regulations, seemingly endless shifts in documentation of eligibility for ACA policies and tax credits, and the implementation of the new ICD 10 will likely make claims payment to providers even more problematic in the new ACA era. New laws like these place new burdens upon all 'players' because of data base and claims payment shifts. We can expect some hitches and glitches in claims payment for some time to come, most likely, while health care companies sort this out.



- **Must have State and Federal Officers 'in-the-field' as monitors – someone who will get 'out there' IN THE FIELD instead of remaining at his desk in the office . . . out there, alert for signs of trouble.**
- **These monitors need an early understanding of problems brought on by the transition to a managed system of care, regardless of its design.**
- **Need someone out there to see and hear 'neglected' or 'under-planned' areas of implementation, unanticipated problems, on an ongoing basis.**
- **Need someone out there to see and hear actual PROGRESS, too – to understand what is working!**



#9 Inadequate Funding At The State and Federal Office Level

#10 Lessons to Be Learned About Cultural Sensitivity and Access

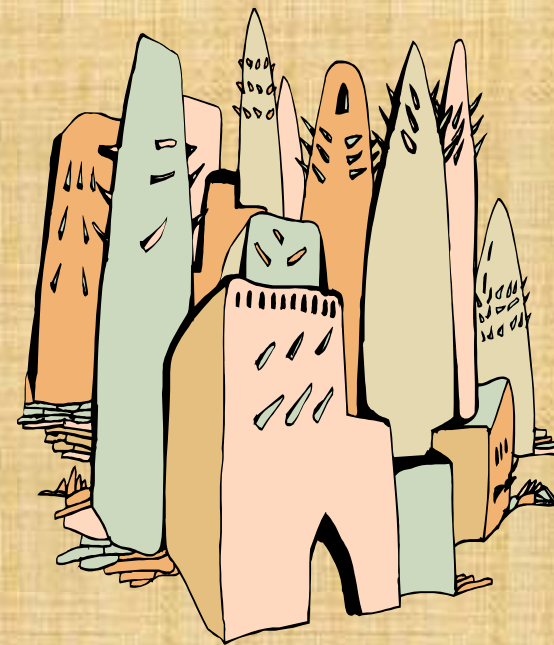


Experience tells us that rollouts often suffer from several cultural and ethnic woes, which result in low levels of service delivery within communities of color.

- **There must be a specific plan to effectively deliver services to high density, high risk populations who reside in inner city enclaves and barrios. There must be a conscious effort to continuously inform ethnic populations about alternatives to the ER for non-emergency needs. We must then support, redirect and reinforce use of the new alternatives.**

Cultural Sensitivity and Access . . .

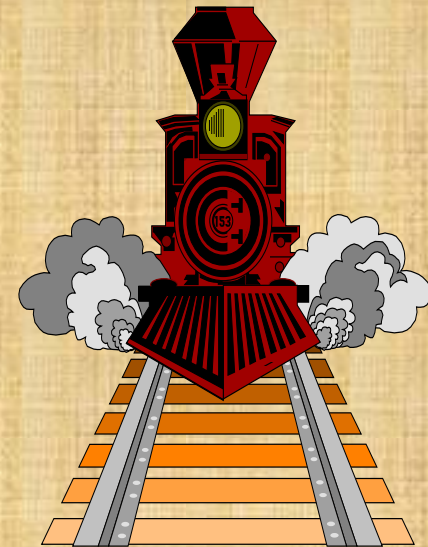
- Oftentimes, few services are located *inside* communities of color. Consumers are expected to travel *outside* their indigenous boundaries – mainly because providers of color within these communities are not systematically sought out.



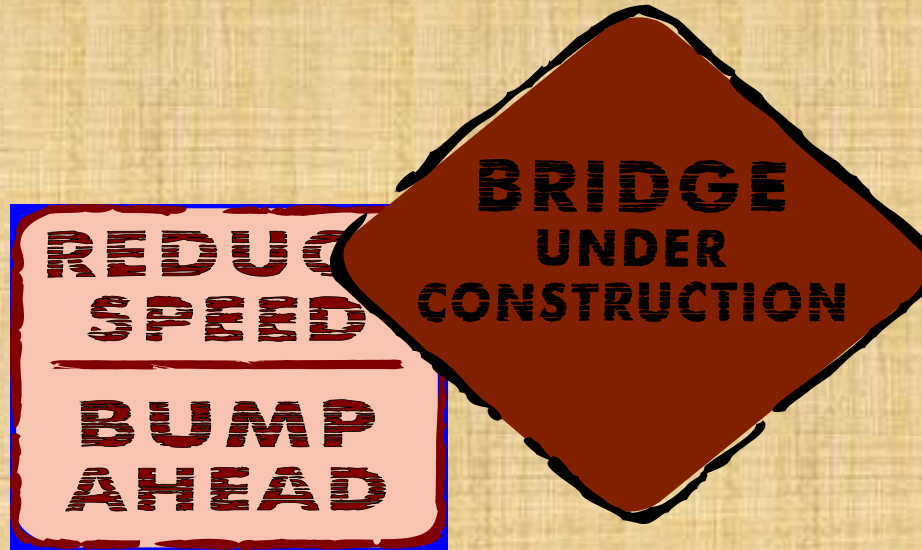
#11 Failure of Crucial Parts of the Current Health Care System to Either 'Board' the Train . . . OR to Be 'Allowed' to Board the Train.



- Some important entities may NOT be participating, e.g., some States have voted to not be full players because of financial stress or politics; many major Hospital Systems have been left out of the network because rates are too low, and some key provider networks may not participate for various reasons.
- Loss of revenue and closing of services by non-participating providers may result, if they do not have divergent funding streams to keep them in business.
- Leads to fragmentation of the system of care in that community



Which of Those 11 Factors Apply (Or May Apply) To Your Situation?



In Module 201 of this course 4A (which is available to take in FlexiCourse 4A if you wish to earn a second certificate, but is not mandatory), we describe some Capitation Contract 'variations' which States negotiate with HMOs (and sometimes with large provider organizations such as CMHCs and CD Treatment Consortiums). Remember that the type of contract that the HMO has with the State significantly affects the type of contract the HMO has with PROVIDERS! We also discuss some creative ways that providers can deliver treatment under a managed care contract.





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