

FlexiCourse 5A

Module 101 Part B of Lesson 1



But How Do They Make This Work,
With Such High Risk?



CARE MANAGEMENT – It's Essential to Control The Cost! Welcome to 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'!

Care Management!

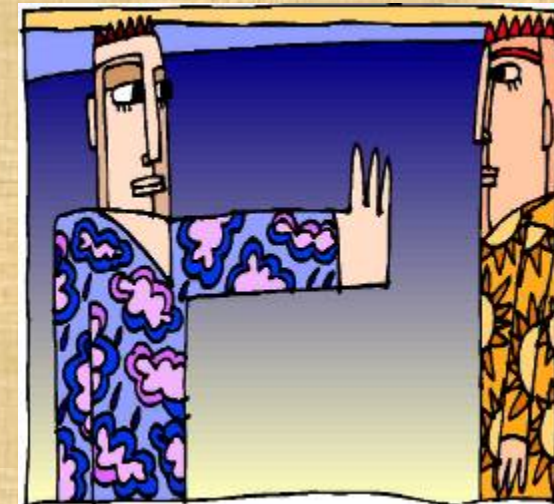
How's it work? The MCO will authorize **ONLY** the care that is **ABSOLUTELY NECESSARY** – i.e., only the care that is 'medically necessary'. They decide if the patient is 'sick enough' to receive a certain treatment. Providers no longer have the freedom to delivery care 'at will' – at least not if they want to be paid for the care they deliver.



When dealing with Behavioral Health (Mental Health, Substance Abuse, Chemical Dependency, or Dual Diagnoses), we are **NOT** talking about being 'physically sick' as in pneumonia or appendicitis. We are talking about mental and behavioral functionality, and safety for self and others. Treatment of these MH and CD diseases can be very expensive!

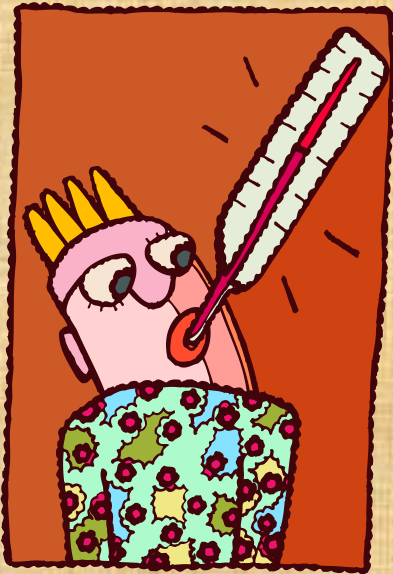
A Couple of MCO Cost Control Strategies

One way that the MCO and the State can control the cost of care is to reduce the number of people the MCO treats with 'high-end' services. How? The CRITERIA that make an ENROLLED person actually 'ELIGIBLE' for certain costly services can be restrictive . . . particularly if money for behavioral health is tight – so that NOT EVERY enrolled individual will be *eligible* for EVERY service. For example, *unless* a patient has a particular DIAGNOSIS, he may be eligible for *very few services*. Or, UNLESS his social and behavioral DYSFUNCTION is chronic and severe, he may not receive services from the healthcare plan at all, after assessment.



The 'worried well' and the 'early stage' drug or alcohol user are disappearing from the Managed Care treatment scene, as money grows tighter.

Cost Control Strategy . . .



Regardless of our feelings about this approach, it is clear that the 'AT RISK' MCO MUST BE VERY CONSERVATIVE in how its contract dollars are doled out to providers, so that the funds will STRETCH to cover the entire year.

What do we mean – 'conservative'? Again, simply this: Under managed care, the MCO will authorize ONLY the care that is ABSOLUTELY NECESSARY – i.e., only the care that is 'medically necessary'. This is the MAIN FORM of cost containment. Providers no longer have the freedom to delivery care 'at will' – at least not if they want to be paid for the care they deliver.



Summary of Care Management: 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.

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.

To Be Successful In This System . . .

We provide details about *'What Can Go Wrong In That Chart?'*, in Course 2B, which earns 2 or .2 CE Credits.

To be successful in this system, the provider may need to rise to the occasion – learning **NEW WAYS to **DOCUMENT** treatment and the **NEED** for treatment, and new ways to **DELIVER** treatment.**



The decisions of the MCO – regarding authorization of your request to deliver treatment and then paying you for it – may well depend upon what you write in the client's chart. That is, how you document the need for the treatment and how you carried out the treatment. Doing what you have 'always done' may not work anymore. 'Coming out of the box' is the name of the game here. Creativity and flexibility are IN.

Documentation Style – It's Crucial to Managed Care Success

- **Managed Care programs are 'not your same old' Block Grant or State Revenue Program. The MCO or other such managed care company is typically dispensing funds 'a dollar at a time' . . . for specific types of TREATMENT interventions, for specific types and severities of PROBLEMS, at specific LEVELS OF CARE(LOC).**




Your documentation of why you requested the LOC, and the treatment you then provided must clearly support this level of specificity.



'Poorly Documented Level of Care' – Deadly!

CRITICAL ISSUE: Your client's treatment record **MUST** support the Level of Care for which the MCO or other such managed care contractor is paying you! If they are paying for one of the more intensive Levels of Care, and your documentation looks like the client **DOES NOT MEET THE CRITERIA** for that Level of Care (i.e., he does not really need that level of intensity), you may have to repay some or all of the money that you have been paid for the period of time that the documentation did not appear to 'match the level'.

- The Bottom Line with MCOs and other such auditors: "Does this chart justify what we are paying them to do the treatment – and is this Level of Care (LOC) really needed – and is it working?" We **MUST** do 'Internal Utilization Management' to assess this LOC issue, on an ongoing basis. 9

 ***The need to do Internal Utilization Management (IUM).*** Remember . . .

Just as the Managed Care Company must carefully MONITOR the progress of the client through 'Care Management' (or 'Utilization Management'), the PROVIDER must *also* closely MONITOR 'how-often-how-much' treatment is needed and how much you have provided.

Therefore you will need to develop an INTERNAL UTILIZATION MANAGEMENT (IUM) PROGRAM, to monitor the appropriate Level of Care (LOC) and the UTILIZATION of services. Just like the MCO must do!



Providers: In this system of care, you MUST do 'Internal Utilization Management' (IUM) to monitor the client's NEED for services AND how much service you have provided to him. Are you 'out of units? Yes? Then you won't be paid until you are 'authed' for more!

Note: Failure to perform this task regularly can result in denied claims or recoupment of claims payments after you have received them!



What's the Impact of 'Level of Care' on How We Work?

Many of the 'old ways' of providing treatment have been discarded or radically modified. Why? A couple of reasons: Funds for health care in general are in very short supply in this country. In order to get a grip on this situation, it made sense that there should be more rigorous management of the treatment we were providing – what KIND, how intensive (how OFTEN), and for HOW LONG?

And also, WHO IS SICK ENOUGH to get the more expensive treatments? This issue has had a major impact on who we treat! This is particularly true for persons with early stage Substance Abuse issues and for treatment of persons with less-than-severe Mental Health disorders – like depressive episodes and anxiety disorders. These individuals may not get many services.

- **You must think about your client's treatment in the same way that the MCO's Care Manager is thinking when he or she reviews the case: "WHY should the MCO spend short-supply money on this case – and for THIS treatment?"**



- **You must put away soft-pedal language and euphemistic ways of talking about the client's problems.**

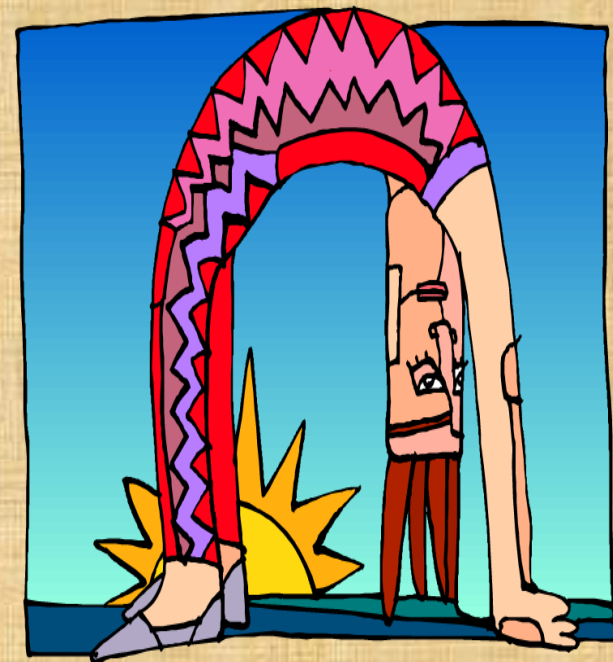
- **You must be willing to address DYSFUNCTION and PROBLEMS as well as strengths, because they do not pay for strengths – they pay for STABILIZATION of DYSFUNCTION, PROBLEMS and SYMPTOMS!**

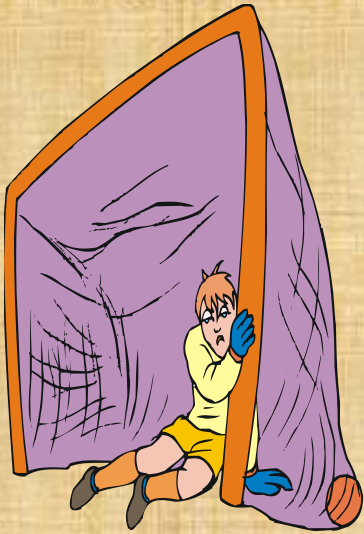
Q: So how, exactly, do the MCOs determine if a particular treatment is **MEDICALLY NECESSARY**? And is the **DIAGNOSIS** enough to determine this?

A: We address this issue in depth in Course 2B. Check it out!

It is true that the managed care company's decisions may sometimes 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 expensive Levels of Care (LOC). How do they limit this? The MCO may 'step them down' to a lower level of care (i.e., 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'.






FREQUENT QUESTION: But do MCOs just cruise through their contract – getting out of one thing after another? Providing little care to persons who are really sick? Typically, the answer to that is NO. The feds and the States will not allow it. And if the MCO allows patients to deteriorate from lack of good treatment, the resulting cost of excessive inpatient care 'does them in', financially.

Yes, MCOs do need to carefully managed the care. And this can be painful to providers and to consumers alike. But the process of determining MEDICAL NECESSITY is indeed the KEY to COST CONTAINMENT - especially for a state that is struggling to control and manage its health care costs. That's why they call it 'Managed Care.'

But why does 'reducing the cost of care' have to change so much of the way that we do treatment?

 The money placed in the care of MCOs and other such managed care companies is typically rather limited, because State legislators are trying to control the cost of health care. Thus the MCO must do what it can to reduce how much money is spent on treatment. In other words, they must **PRIORITIZE** who gets treatment, and what they get, and for how long!



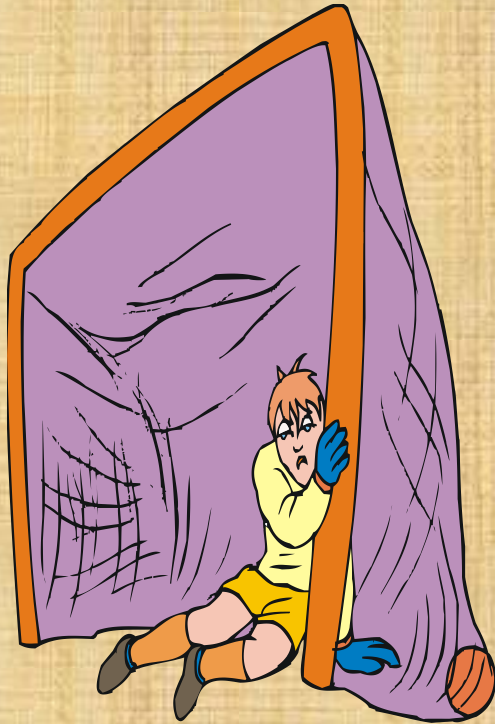
Will all be rosy if the provider cooperates?

NO. Managed care participation can be challenging all the way around. We talk about this in detail in Course 5B – ‘Where the Rubber Meets The Road’, which earns 5 or .5 CE Credits.



Ok, but what kind of issues might providers encounter? Occasionally managed care companies engage in practices that are at best manipulative – intended to regulate their CASH FLOW on a daily basis. Like what? Like delaying the pay-out of treatment dollars, even though they do indeed eventually pay the provider all that is coming to him. And, like BENCHING which we describe momentarily.

Cost control . . .



CASH FLOW CONTROL: MCOs are occasionally known to use strategic methods to control their immediate day-to-day CASH FLOW, particularly near the end of the month or the end of a fiscal quarter. This is perpetually vexing to providers even though things eventually 'work out'. What are we talking about? Some MCOs are suspected of delaying the payout of providers' claims, through one mechanism or another - even though eventually the provider does collect what is owed to him.

Another method is **BENCHING**, described on the next slide.

Benching . . .



BENCHING is a **DELAY** in giving a decision to a provider about whether a patient can be admitted to a particular service – leaving providers and patients feeling ‘left out in the cold’ until an answer is given. This practice may occasionally occur when a request is made to admit to inpatient treatment or to other expensive services such as detox or partial hospitalization.

Though not a rampant trend, States and other major contractors tend to watch such practices (including unnecessary delay in payment) closely. Providers may report such practices to the State, if to excess.



Yes, Care Management can be hard to live with.

The implications of 'CARE MANAGEMENT' (the MCO's term for deciding what services will be approved for a specific patient at this moment in time) and the PAPERWORK that goes along with it are 'major' for providers. And sometimes the impact is impossible for a provider to 'live with'.



We provide details about Care Management and how to deal with it in Lesson 2 of Course 2B - *'Medical Necessity', 'Level of Care'* and *YOUR Documentation – Yes, They ARE Connected!*

Retraining, Culling, New Hiring Practices . . .



In fact, retraining, 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 'managed care occasion'.

Some people will stay, some will go. Those who choose to stay will have to make significant shifts in how they **THINK** about and **DO** treatment, and also in how they **DOCUMENT** what they have done, in their clients' **TREATMENT RECORDS.**

We provide details about '*What Can Go Wrong In That Chart?*', in Lesson 3 of Course 2B.

Nevertheless, There Are Some New and Creative Ways to Participate in Managed Care – Out Of The Box, Ready or Not!



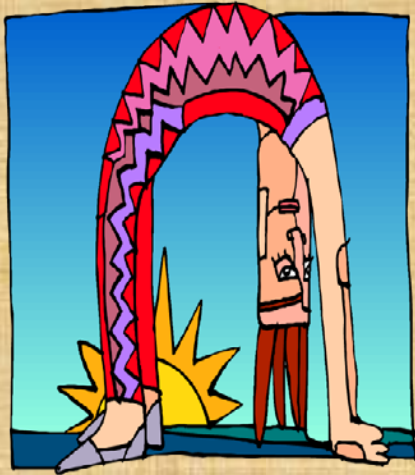
In Lesson 2 of Module 201 of this course, we give you some good examples of creative ways that providers can participate in delivery of managed care services. Some entail a bit of 'risk' for the provider but are mostly safe (minimal, manageable risk) and are eagerly sought by providers across the country. Your practice or program may already be engaged in one or more of these creative contracts, and if not, you may wish to consider it!

Shifting Where and How the Money Is Spent

- In managed care programs we CAN **SHIFT** where the funds are currently being spent – and we 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 our 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 that is **GOOD** for community providers!

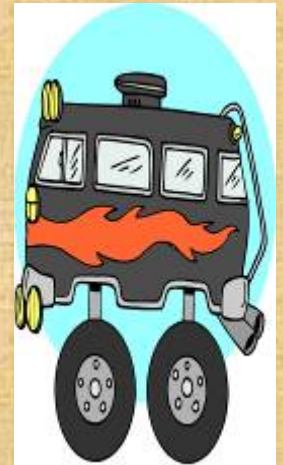


Providers can benefit from this shift!



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! 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!



SUMMARY: Capitation Can Work IF . . .

**Despite the risks, we know that the type of contract we have described here –
Capitation – CAN and DOES work for MCOs
and other such major contractors, IF and
only if these conditions are met:**



📁 **The State's original predictions MUST hold true . . . about the COST of services, and how MANY enrollees will actually seek services, and what KIND of services will be needed, and how MUCH, and**

📁 **The FUNDS ALLOCATED to the program MUST BE adequate and must be carefully managed!**

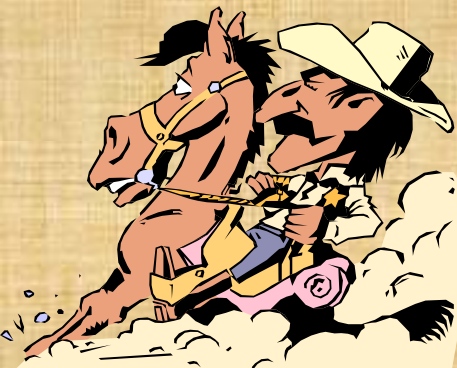
With a Caveat . . .

EVEN SO . . . we want to be clear that NOT ALL forms of CAPITATION are workable or desirable (in our opinion) EVEN WHEN those 2 conditions are met.



***At least,
'The Bad'***

In fact, there is one form of capitation that is (in our view) *at least* 'The Bad' . . . and sometimes 'The Ugly', in the world of managed care contracting.



***Maybe Even
'The Ugly'***

What are we talking about? **SUB-CAPITATION**, discussed in Module 201 of this course 5A, which looks at The Good, The Bad, and The Ugly of contract design.

Are There Options In How Managed Care Plans Are Designed, Which Can Avoid Some of the Potential Problems?



YES, there ARE options in how a State designs its managed healthcare plans.

Many state-sponsored Managed Care plans 'go all the way' with full-blown 'total risk' capitation contracts, *from the outset*, BEFORE doing any managed care pilots. And some may jump into an 'all inclusive' funded capitation arrangement, rather than limiting the conversion of the funds to Medicaid or to one Block Grant or another.

Options . . . ?

☞ State governments CAN choose to move slower than this. They may want to consider a scaled-down or 'phased in' managed care model – keeping some of the 'old' features of the delivery system, at least for a while, to give the system a chance to adjust, moving the new approaches in slowly.

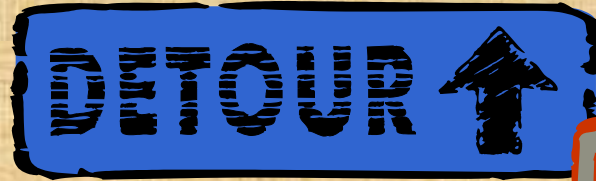
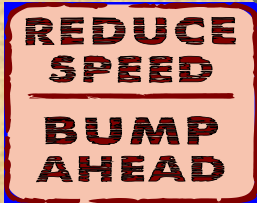


- ☞ Providers and advocates may want to press for 'phasing in' managed care, in states where managed care is not yet in full swing. And they may want to press for 'simplicity' in the design of the plan.
- ☞ The number of problems experienced by providers and the MCOs correlates highly with the complexity of the Managed Care Plan.

Who can benefit from understanding these issues?



- **Governmental (State, local) planners and administrators – who need to consider all of the angles, the upside and the downside, the ins and the outs, before forging a plan.**
- **Program administrators and managers, provider networks and individual practitioners – who must be *proactive* in advocating for workable solutions to managed care implementation.**
- **Mental Health and CD/AOD Advocates and Consumers – this is *your* system they are preparing to change. Be proactive!**



In the next lesson we will present 11 Weak Links which we believe cause many of the problems in managed care programs.

Congratulations!

You have completed Lesson 1 for Module 101 of this course. You may complete the short quiz for this lesson either now or later. To reach the quiz link, close this page and you will return to [My Home Page](#) , go to quizzes for Module 101- and click on Lesson 1. Or move on to the next lesson.

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

So either take the quiz now, or you may resume the course – your choice! To move on to the second lesson of Module 101, return to [My Home Page](#) and click on Lesson 2, Module 101.

