Welcome to Course 1B – Intro to Behavioral Health Programs Within a Managed Care Environment – *It's Not Your Grandpa's Chevy*

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Intro to Behavioral Health Programs Within a Managed Care Environment – *It's Not Your Grandpa's Chevy*

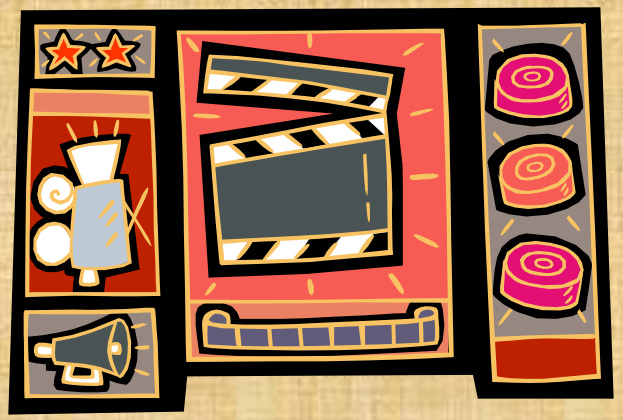
This FREE mini-course provides an introduction to the main goals, clinical issues, concerns, and opportunities for providers within this new cost-conscious treatment environment.

This course has two sections ('study guides') and two short quizzes. Enroll in this course for FREE and enjoy! And then take 2 short quizzes for a total of 1.5 credit hours and 1 EACC PDH.

You say that you don't plan to have anything to do with Managed Care? Regardless of WHAT type of contract an insurance company might have with providers, we believe this: Working with a managed care company – OR ANY INSURANCE COMPANY in this day and age – involves major clinical and programmatic CHANGES. This mini-course is an introduction to what has changed in the mental health and AOD fields and what providers need to do to work effectively within the cost-conscious Health Care Reform movement.

So, is this course simply an 'introductory business course' about the contracts and paperwork involved in doing business with an insurance company? No. Understanding how behavioral health Managed Care works – and all of the clinical changes that go with it – is the key to continuing the treatment of your clients in a 'post-recession', 'pro-recovery' Health Care Reform environment.

***The next few slides are a preview of the second half* of this FREE 1.5 credit hour course. (OK ☺ . . . we know that Managed Care is not the most stimulating of subjects, and we want to keep your attention.)**



The second half of this mini-course (Lesson 2) focuses primarily upon the oftentimes challenging CLINICAL changes and requirements which come with Managed Systems of Care. Here are a few slides from Lesson 2:

Like It or Not, It's 'Disease Management' – Not Social Service

- **Managed Care is 'Medical Model' – and we must adapt what we write in treatment records (charts), accordingly. The managed care approach is becoming increasingly 'medical' in orientation.**

- **'Medical' means TREATMENT – not simply social service or support. Health plans pay for TREATMENT which targets DYSFUNCTION**

- **When delivering Health Plan services to individuals with behavioral health diagnoses, we must think 'clinical' and 'treatment' and 'remediation of dysfunction' when we DOCUMENT the treatment we provide – which may be a major shift for many professionals.**

We must crank up the 'treatment' perspective. We must make clinical-sounding statements (not just social service talk) in everything we write.

We must think 'Level of Care'. It's what drives everything!

We must think 'LEVEL OF CARE' in everything that we do . . . when we ask for approval to provide treatment, and when we are delivering and documenting the service. This applies to all clients (except perhaps those who are 'private pay') regardless of age, sex, or diagnosis.

Note: And even with private pay clients, our licensing regulations prohibit most of us from delivering services that are not benefiting the individual. We simply have a bit more latitude with such clients.

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

Many of the 'old ways' of providing treatment have been discarded or radically modified. Funds for health care in general are in very short supply in this country. In order to get a grip on this situation, it makes sense that there must be more rigorous management of the treatment we provide – i.e., what KIND, how INTENSIVE, how OFTEN,, and for HOW LONG? This is what "Level of Care" decisions are all about.

The Issue: WHO IS SICK ENOUGH to get the more expensive treatments? This issue has had a major impact on who we treat – and at what LOC! This is particularly true for Chemical Dependency services and for treatment of persons with less-than-severe Mental Health disorders – like depressive episodes and anxiety disorders.

Care Management and Level of Care – How's It Work?

"Just how sick is he?"

Specifically . . . the Care Manager must decide what Level of Care (LOC) is truly essential (read: MEDICALLY NECESSARY) in order for your client or patient to improve. And if we ask for more treatment down the line, how has he or she *responded* to treatment thus far? It requires a whole new way of thinking! And the Care Manager looks for 'holes' in our thinking and in our records, when making LOC decisions.

“What?! You say there might be holes in my thinking? And in my records? Surely not! They’re 3 inches thick! How can there be HOLES?”

Well, yes, there can be. And we’ll tell you what they are – for example, the following slide . . .

The PASSIVE REPORTER Syndrome: Assessments and Progress Notes that simply REPORT what the consumer or family member SAYS about the issues and problems – failing to express our own clinical observations and conclusions.

- **We all know why some of us still do this type of documentation – the 'Say Nothing Significant' approach. We were trained to document as little of our own clinical thoughts as possible because (1) you don't want to be judgmental, and (2) you might be called to court to explain your comments.**

- **This type of PASSIVE assessment and progress notation is NOT helpful under a managed care scenario. The managed care company is paying you to give every ounce of professional skill that you can bring to the table, to ASSESS, TREAT, and STABILIZE this person's DYSFUNCTION. They want to know 'What do YOU, as my CONTRACTED PROVIDER, THINK about this case.' Don't be vague or cryptic!**

We'll do more of this clinical stuff in the second lesson of this course.

Now on with this free course!

Managed Care Is NOT an Issue Only in Public Health Care Programs. It Applies to Those in Private Practice, Too.

Many practitioners think that they won't be affected by the move to Managed Care – they believe that it only applies to Medicaid and Medicare. NOT SO. Commercial (private) insurance carriers are already moving into this way of doing business with the providers on their 'panel'. So whether you work in a Community Mental Health Center or Block Grant Chemical Dependency Treatment Program or other agency setting – or in Private Practice – this information is relevant to you.

A note on terminology.

NOTE: Companies which are participating in this newly expanded approach to healthcare carry various labels - including Health Maintenance Organizations (HMOs), or Managed Care Organizations (MCOs), or Behavioral Health Organizations (BHOs), or 'Health Care Insurance Companies', or Health Insurance Exchanges (*'The Marketplace'* within ObamaCare). In this mini-course, at times we may refer to any and all of these companies as 'MCOs', unless there is a specific reason to differentiate. And because most insurance companies are now VERY careful how they spend their money, we shall refer to this new cost-saving approach as 'Managed Care', regardless of who is administering the contracts.

In addition, when we speak of 'controlling costs', what we say applies to parts of the new federal Health Care Reform movement (known as ObamaCare or the Affordable Care Act – 'ACA') – which was brought into law in March 2010 but did not become 'real' to most people until 2014. We approach this course NOT from a political standpoint, but rather in terms of the intent of the ACA to cut and control the cost of health care, and to make services available to more individuals – and to encourage some new ventures among providers who may not have been doing this type of business before.

No one knows how the federal Health Care Reform movement will evolve, or even many of the details within – except that whatever shape it takes, control of costs will be central. And that means more 'Managed Care'.

What Are the Primary Goals of the 'Managed Care' Approach to Health 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**
- ***However we must do it, control the cost* of healthcare!**

But First You Need to Know About the Potential Impact of the Affordable Care Act (ACA) Upon Providers, Including Some 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.*** **Goal: Health Care insurance and high quality, effective medical treatment for the entire US population, at a significantly** ***reduced cost – with much of it paid by the Federal Government.***

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.

So who is actually providing the medical and behavioral health treatment? Health Insurance Exchange Companies within the Marketplace are contracting with *selected provider networks* to deliver the care at a reduced cost.

To reduce the cost of care, the Marketplace's insurance companies 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' services. And the straightforward 'fee-for-service' model – where 'more service' is better for the provider – is going away. 'Big Insurance' wants a 'package deal' whenever possible.

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.

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'.

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!**

‘But . . . They’re Changing Up So Much of What We Do – and How We Do It. Why?’

OK - 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 the need for ‘Cost Containment.’ Which sounds OK, but . . . is that always a good thing?

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

Some goals in Healthcare Reform are good and may be attainable. Some may not be successful. If a major goal of a new healthcare plan is to immediately "fix" the system, it's unlikely to succeed, and it could in fact damage the system.

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

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 Insurance Companies and MCOs in their Care Management process) are believed by many to result in 'questionable clinical outcomes' for Chemically Dependent consumers. Reason: These 'Care Management' protocols may not adequately accommodate the CD population's inherent tendency to relapse repeatedly while they are on the road to recovery.

A CD Issue Related to Care Management Decisions . . .

What to do here? For your most relapse-prone clients – especially those who are 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'. (More about that in the second half of this course.)

Most significant of all – The States and the Feds *and* the Insurance Companies are shifting where and how the treatment money is spent!

- **In managed care programs, the Insurance Companies CAN SHIFT where the funds are currently being spent – and can oftentimes do it with better outcomes! IF in fact the outcomes are better, it's hard to argue that this is not a good thing. In fact, this is one of the most valid goals of managed care – doing something to improve on current programming results.**

- **How does this work? The MCO or other insurance company 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 – if they want to participate in developing new programs – and it's good for our clients if new programs result!**

Does the Insurance Company always make money? NO. In a 'capitation' or 'risk based' contract, sometimes the MCO runs out of money before the end of the contract period – but they still have to provide the care. That's why they call these big health care contracts "AT RISK" contracts.

So given these shifts in goals and expenditures, what are we seeing?

Those dependable annual State contracts with Community MHMR Centers and Chemical Dependency block grant holders are going by the wayside. To survive with some level of comfort, ***traditional providers are having to change up what they do, or give the business to someone else (like private providers).***

It's no longer your grandpa's Chevy!

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

This is part of the cost containment effort. New to the system, or here for 30 years – there is no preference here. It's whoever will do the job.

The Insurance Companies 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 Insurance Companies 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.

‘Does this mean what it sounds like? Are Insurance Companies re-designing the delivery system?’

Well . . . yes. They are. The new Health Care Reform has resurrected Managed Care to a new level of significance. And to stay in the game, we’ll have to figure out how to fit in.

Q: Ok, but what about OPPORTUNITIES for providers? Are there REALLY any opportunities for us?

A: Yes. You'll see a couple in the next (and last) lesson of this free course.

This is the end of Lesson 1 of this short FREE COURSE. Time to move on to Lesson 2! You can take the short quiz for Lesson 1 now if you wish – or later. Whatever works for you!

To access Lesson 2, simply close this window (this lesson) to return to your list of Study Guides and Quizzes. If you want to return to your course or quizzes later: Just LOG IN to our site with your USER NAME and PASSWORD, which will take you to you're 'My Home Page'. Click on your course, and we'll take you to your Study Guides and Quizzes page. Click where you want to go: Either Lesson 1 or Lesson 2 of Course 1B, or the quiz for either. There are two study guides and 2 short quizzes in this mini-course.