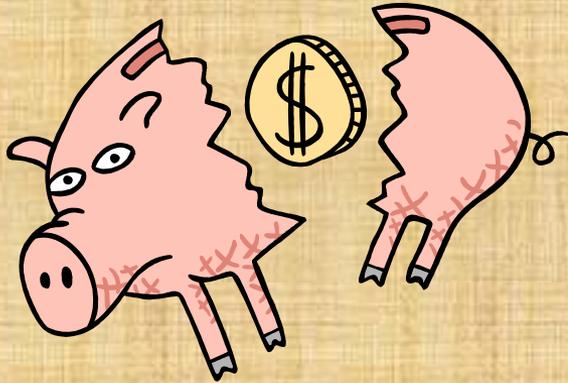


Lesson 2

Course 3A



Understanding 'The Bad' Behavioral Health 'SUB-Capitation' Contracts . . . And More.

Remember What Capitation Looks Like?



In true **CAPITATION**, the State pays the HMO or other major contractor a pre-determined, fixed \$\$\$ amount every month (such as \$6.25 or \$11.30), for **EACH** person

who is **ENROLLED IN** or covered by the healthcare plan during that month. (This is known as the 'per member per month', or 'pmpm' payment.) There must be thousands of patients enrolled in order to ensure a large enough monthly payment to the HMO or other managed care company. Even so, you say, \$6 or \$11 per-member-per-month doesn't sound like much money to take care of an individual, does it? And then we saw how they do it – through many different maneuvers which **CONTROL COSTS**. And there are multiple problems which can occur.

Ok. In this lesson, we'll move on to **SUB-Capitation**.²



But before moving on to a variation of capitation, i.e., SUB-capitation . . . are there options in how managed care plans are designed by states, which can avoid some of the potential problems?

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



Many state-sponsored Managed Care plans 'go all the way' with full-blown 'total risk' CAPITATION contracts for Medicaid *from the outset*, BEFORE doing any managed care pilots. And some may go even FURTHER: They may do an 'all inclusive' or 'all-funds' capitation arrangement for Behavioral Health , RATHER THAN limiting the conversion of the funds to Medicaid or to one Block Grant or another! Want an EXAMPLE?

Options . . .

An example of an 'all-inclusive' or 'all-funds' managed care plan for Behavioral Health is a BLENDED FUNDING Capitation arrangement. This is where an HMO takes on and manages ALL of the Medicaid behavioral health funds AND all or most other behavioral health funds within a geographical area . . . for ALL disability groups including Mental Health (MH), Chemical Dependency (CD) and Substance Abuse (SA) . . . and for ALL ages (adult and child) . . . taking even the Community MHMR Center and SA/CD treatment funding. We'll look at this in some detail later on in this course. It's the type of plan that can be The Ugly – but eventually become The Good. Sort of an 'Ugly Duckling Into A Swan' story.



Options . . .

☞ State governments CAN choose to move slower than these FAST TRACK approaches. 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.

☞ **NOTE:** The degree of complexity and the scope of the managed care plan design typically correlate highly with the number of problems. That is, the more complex and 'big' the plan, the more problems!

On To The Good, The Bad, and The Ugly in Managed Care

In the previous lesson, we said that **CAPITATION** is the main way that States control cost of programs like Medicaid and Medicare. And we said that **CAPITATION CONTRACTS CAN WORK.**

HOWEVER, we do want to be clear about our belief that **SOME** kinds of capitation contracting can be 'The Bad' . . . and sometimes 'The Ugly' . . . in the world of managed care contracting. What are we talking about? Well, **SUB-CAPITATION,** for one! Read on . . .



'The Bad'



'The Ugly'

Sub-capitation – What Is That?

This is a variation on the **CAPITATION** theme which takes things a step further. In this arrangement the State *initially* signs a **CAPITATION** contract with one or more HMOs or BHOs (Behavioral Health Organizations) and the HMO or BHO is carrying all of the **RISK**. (Remember what **RISK** is from the previous lesson.)

But **THEN** the HMO or BHO decides (with State approval) to *carve 'out'* (or pass on down to another entity) most of the contract funds. Why? Because they want to **OFF-LOAD THE RISK OF FINANCIAL LOSS** onto another organization. This is the ultimate form of an HMO or BHO 'controlling its costs'.





Sub-capitation . . .

So the contract funds are passed down, *along with the risk*, to this second managed care company or other organization – which may even be a large PROVIDER ORGANIZATION. That company or organization then acts as the Behavioral Health Organization (BHO) which ‘manages the care’ of the enrollees.

If this second company is not another managed care company, it is most likely a Hospital District, or a large Community Mental Health or Substance Abuse Provider Consortium, or some other statewide professional group. They now hold the capitation money (what’s left of it) and also the RISK that they will LOSE MONEY in the process of ensuring that all of the enrollees get MEDICALLY NECESSARY SERVICES.

Sub-capitation . . .

Through this maneuver, the original HMO or BHO has not only 'OFF-LOADED' its risk to the new 'carve-out' organization – it has ALSO peeled off a percentage of the contract money for its own 'administrative costs', before the pot of money is given to the new organization. *So what is wrong with this?*



***Usually
'The Bad'***



Sometimes The Ugly!



Sub-capitation . . .

- **The problem is this: This option is messy – often deceptive. A total of 10-15% of the original funds may be retained for ‘administrative’ purposes by the original HMO [a.k.a. ‘administrative rake-off’] – and then ANOTHER 10-15% will be set aside (‘raked off’) for administrative costs by the new ‘carve out’ company. Thus, there is considerably LESS MONEY AVAILABLE for direct care of patients after all is said and done. Look at the next slide.**
- **If this option is allowed, the State should at least *prohibit additional* sub-caps or ‘off-loading’ of risk even further down the line (which would be a ‘Serial Sub-Capitation’).**



Behavioral Health Sub-Capitation – Where's the Money Go?

This is how the MONEY flows in this model.

From the State



**To the primary contractor(s) – one or more HMOs or BHOs,
who hold all of the money and all the risk**



**To the SUB-capitated HMO or BHO, who takes approximately
90% of the original money and all of the risk**



To the Final Providers of Services.

**Note that there is an 'ADMINISTRATIVE RAKE-OFF' of approximately 10% before
the funds are passed to the Sub-Capitated entity. And then the sub-capped
entity has its own administrative costs to pay, out of the 90% that it receives.
Leaves maybe 80% of the original funds for client care.**

Can it get worse? **YES!** It's *Serial Sub-Capitation* – and it's definitely 'The Ugly'



- **Serial Sub-Capitation** [Some simply refer to this as a **Sub-Sub-Cap**] – This is a contract model in which the **NEW** sub-capitated organization (as in the previous slide) **OFF-LOADS (OR TRANSFERS)** its assumed risk **AGAIN**, by passing the money and the risk down to a **THIRD** party. This might be a **CMHC**, a large group practice, a physician group, or not-for-profit association. This is **SERIAL SUB-CAPITATION**.
- This *newly* sub-capitated group or organization then either provides the services themselves **OR** contracts with and pays other providers below them – perhaps does both of these things.

Serial Sub-Caps . . .



What's the problem here? Both the *original* HMO and the *original sub-capitated* organization hold out a chunk of the funds for 'administrative costs' . . . and the third organization (the second sub-capitated group) will ALSO hold out some of the funds for administration. So not much is left for the providers OR the patients! Want to see a graphic flow chart of how the money travels? Read on . . .



Behavioral Health Serial Sub-Capitation – Where's the Money Go?

This is how the money flows in this model.

From the State



**To the primary contractor(s) – one or more HMOs or BHOs,
who hold all of the money and all the risk**



**To the SUB-capitated HMO or BHO, who takes approximately
90% of the money and all of the risk**



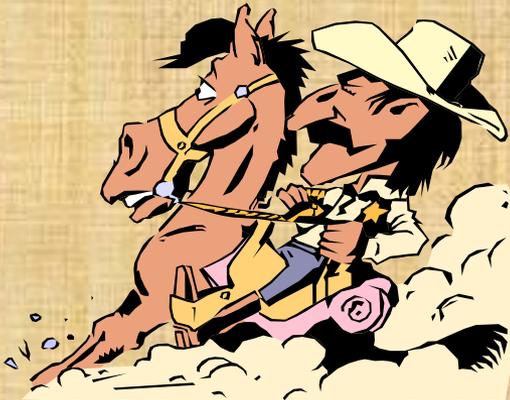
**To ANOTHER 'SUB-capped' entity - perhaps a Community
MHMR Center Consortium – who takes approximately
90% of the remaining money and all of the risk**



To the Final Providers of Services . . . way down the line!



The fact that capitation is such a HIGH RISK arrangement is precisely why some HMOs and BHOs may try to OFF-LOAD the risk to a third group down the line, through SUB-CAPITATION of their original contract.



The Ugly

Unfortunately, some HMOs feel that PROVIDERS are as good as any to take on this transferred risk. When that happens, we believe that this is “The Ugly” of “The Good, The Bad, and The Ugly” in contract design.

Important Notes For Providers About Capitation



Capitation or Sub-Capitation may be tempting for a 'large' provider organization to take on – especially if it wants to maintain 'control' over the shift to managed care. However, no matter how well managed, the risks are still great with ANY true capitation contract. Therefore, providers must be extremely wary of taking on such high risk 'capitation' or 'sub-capitation' contracts, even if they are tempted to do it.



 **NOTE:** In general, *CEU By Net!* believes that ANY type of full-risk capitation contract (Capitation or Sub-Capitation) is generally **NOT WORKABLE FOR TREATMENT PROVIDERS** to take on (as the risk holder), no matter how 'big' the provider is; we believe that true capitation contracts are safe and workable **ONLY** for big companies with millions of dollars held in reserve to cover potential losses – and even then, some HMOs will and do lose money.

**NOW lets look at one type of
Managed Care contract that can be
'THE GOOD' among managed care
contracts – AFTER a 'BAD' or even
'UGLY' break-in period!**



Blended Funding Carve-Outs – *Sometimes* 'The Ugly' – But Oftentimes 'The Good'

Blended Funding Behavioral Health Carve-Outs – CAN be one of the 'The Ugly' managed care contract designs, *at least initially*. But after a 'break-in period' and with careful management and State oversight, can move into 'The Good' category.

This is a funding arrangement in which behavioral health funding from *multiple* community and governmental funding sources is consolidated into a single large pot of funds, and is given to a behavioral health managed care company or large service provider to manage. The blend may include Block Grant funds (CD, MH), General State Revenue dollars, Medicaid, and various local match funds.



**The Ugly?
Sometimes!**



**The Good?
Eventually!**

Blended Funding Carve-Outs . . .

- **Can be dangerous, especially when not prefaced by a true incremental pilot. There are multiple ways to do pilot phase-ins such as this, including 'shadow billing' pilots where providers do a practice run on estimating the revenue they will (and will not!) collect under managed care.**
- **Because it takes ALL or most of the money in the service area and pools it into one big pot, it may initially dismantle or stress the 'traditional provider' delivery system, may temporarily damage or disfigure the 'safety net'.**



- **Downside: May create havoc for a period of time, may take some traditional providers out of the game, and may leave some consumers who were formerly covered by one of the 'annexed' funding streams without services.**

- **Downside: Places traditional providers at grave risk – IF they are not diversified in their funding base (i.e., if they rely exclusively upon block grant or State General Revenue annual contracts). They must 'come out of the box or die'! Must diversify their funding streams.**





**YES, there is
an up-side!**

Blended Funding Carve-Outs. ... They DO have an upside!

Upside: IN THE END, Blended Funding BH Carve-Outs can produce a viable and newly configured delivery system, with expanded CHOICE of providers for consumers, greater FLEXIBILITY to for providers to offer innovative services, enhanced CREATIVITY brought about by competition among providers, and more cohesive SYSTEMS of care, across multiple agencies.

Blended Funding Carve-Outs . . .

- **Additional Benefit:** Consumers who move 'on' and 'off' of Medicaid eligibility may not lose their services when 'off', under this plan. They may be able to continue services (likely with the same provider) because there are other non-Medicaid funding mechanisms blended in, which can cover their care. In this case, the consumer likely 'never knows the difference'. It is all one big pot of funds, now.



Blended Funding Carve-Outs with CD / SA

- **Caveat:** Many feel that the positive effects of Blended Funding BH Carve-Outs are primarily applicable to Mental Health providers and services and consumers – and are NOT necessarily as beneficial to Chemical Dependency providers and consumers. Although there is room for innovative services and enhanced creativity for CD/SA providers, many feel that the nature of chemical dependency treatment is somewhat at odds with the limitations that HMOs provide on treatment.



Blended Funding Carve-Outs with CD / SA . . .

Caveat, cont. . . . In Blended Funding Carve-Outs and other managed care contract models, the standardized protocols which are often used by the managed care companies are believed by many to result in **QUESTIONABLE CLINICAL OUTCOMES** for chemically dependent and substance abusing consumers. Reason: The somewhat standardized CD/SA protocols used by the HMOs to control costs may **NOT** adequately accommodate the CD population's inherent potential for repeated relapse on the road to recovery.



Blended Funding Summary

- **Avoid the 'Pie In The Sky' scenario! The Key to Success Here: Incremental, step-wise pilots to carefully prepare the entire system for the shift in 'who' manages the healthcare \$\$\$ (now, it is the managed care company, not the provider) . . . and 'how' the \$\$\$ are earned. As providers, we must also pay attention to the need to diversify our income (seek out multiple sources for revenue – don't just rely on this one contract). These are the major checkpoints to success in a Blended Funding Carve-Out! It can be done, and done well!**





Congratulations!

You have completed Lesson 2 of Course 3A. You may complete the short quiz for this lesson either now or later. To reach the quiz link, simply close this page and you will return to [My Home Page](#) . . . and click on Quiz 2, Course 3A.

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 third lesson of Course 3A, close the page to return to [My Home Page](#) and click on Lesson 3, Course 3A – or you may return to it later.