

Welcome to Course 4A – The Little Course In Managed Care!

**Module 101.
Managed Care: It's
Not Your Grandpa's
Chevy!**



**Module 201. The
Good, The Bad,
and The Ugly –
Including Good &
Bad Options for
Providers**

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The Basis of This Information

**“Lessons From Real Life In The
Conversion of Public Healthcare Dollars
To A Managed System of Care”**

- Naylor and Associates - CEUbyNet!



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, Medicare, and the ACA (ObamaCare). 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's Affordable Care Act). 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.

... a note on terminology ...

In addition, when we speak of 'controlling costs', what we say applies to most of the new federal Health Care Reform movement (known as ObamaCare or the Affordable Care Act) which was brought into law in March 2010. This is not approached from a political standpoint, but rather in terms of the intent to cut and control the cost of health care, and to make services available to more individuals – and to encourage some new ventures among companies which may have not been doing business before.

No one knows how the federal Health Care Reform movement will play out, 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 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*. Treatment to the entire US Population was to be paid for – at a significantly *reduced cost*.

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.

The Marketplace's Health Insurance Exchange Companies then contract with selected provider networks to deliver the care at a reduced cost.

To reduce the cost of care, the 'Marketplace' or 'Exchange' companies must 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' (rather than upon a 'fee-for-service' model where 'more' is better for the provider).

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.**

Trying to accomplish – what, exactly?

The designers of new managed care plans need to be clear about what they are trying to accomplish, in terms of **COST CONTAINMENT**. What are they trying to do, exactly? Are they trying to . . .



📁 **REDUCE FUTURE** spending *below* current spending? Hopefully not! Most treatment systems are under-funded already.

📁 **KEEP** the amount that they are spending **NOW**, but hold the line there? Like, a **NO GROWTH (NO INCREASE)** budget in the coming years? Really? No growth. . . ever?

📁 **SLOW** the budget's growth in a responsible way, and utilize the current budget **MORE EFFECTIVELY?** Now that sounds better! We can do this!

More on Cost Containment . . .

The immediate goals of the State's contract designers can have a tremendous impact on the success of the new plan. Some goals are good, some are not.

- An up-front **REDUCTION** in the State's **CURRENT** behavioral health budget is likely to **NEGATIVELY AFFECT** quality.
- In fact, quality will probably suffer if the State cuts back the amount of money that it **CURRENTLY** spends on healthcare!



Again, we want to emphasize that **Managed Care is NOT** the solution to a grossly under-funded behavioral health care system!

Is a new managed care plan under-funded?

Yes? Uh-oh!


A major GOAL and theme of Managed Care is to **CONTROL THE COST** of health care – ‘Cost Containment’ – and **IMPROVE** the **QUALITY** of care at the same time. And so the State must be very careful about how much money it puts into the new managed care plan, when it seeks to control costs.

- **INSUFFICIENT FUNDING** of managed care conversions will almost surely lead to failure of the plan and/or a reduction in quality.
- If programs were clearly underfunded *before* the conversion, the conversion is not likely to succeed with *less* money in the pot than there was before.



Goals . . .

Stated more plainly, cutting the total funding in the first or second year of a managed care pilot IS DANGEROUS.

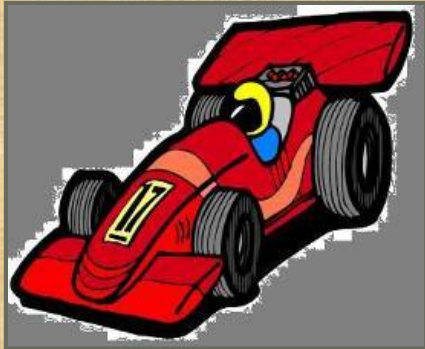
-  **Why? Consider this: States new to managed care don't know what Managed Care can do in their state, or how they will operate it, or what benefits there will be . . . or what the problems will be. Thus, we cannot cut the budget in a way that makes sense, right off the bat.**



Here are some of the GOAL-ATTAINMENT methods that we are seeing around the country, in Behavioral Health Managed Care:

- There is almost ALWAYS a need to obtain PRE-AUTHORIZATION (i.e., 'Care Management' or pre-approval by the Managed Care Company) to deliver services to the consumer, if you want to be paid for the service. Providers can no longer deliver services 'at will'. They must REQUEST permission through a process called CARE MANAGEMENT, which is a way of ensuring that those persons who are most in need of services get those services – and in the right amounts at the right time. Providers may not get what they ask for.





And what else? The STATES and the FEDS appear to be quite committed to cost-saving RISK BASED Managed Care contracts with 'Big Business' – such as large Health Maintenance Organizations (HMOs), or occasionally very large provider groups – who will manage the money and will provide or arrange ALL of the treatment that patients receive. This is an integral feature of the ACA 'Marketplace' or 'Health Care Exchanges.'

**The MONEY is
changing hands,
all around!**



HMOs, BHOs, and other big contract managers are now holding the 'healthcare money bag' in more and more states, instead of the State or a local government agency managing the healthcare funds themselves. This trend may also apply to other funds as well, such as chemical dependency / substance abuse (CD-SA) BLOCK GRANT FUNDS and other 'state contracts' which have – in the past – been awarded to a select group of CMHCs and CD Treatment Providers.



So where are the STATES moving 'to', with the Provider Agreements? Many states have already moved away from fixed open contracts which simply say 'go forth and do good'. Instead, they use FEE-FOR-SERVICE FUNDING MODELS (i.e., you get only the money that you EARN, one session at a time) instead of fixed annual contracts. With Fee-For-Service, there is NO 'regular monthly check' coming in the door. This is a major part of the COST CONTAINMENT strategy.

**Those dependable
annual State contracts
with Community MHMR
Centers and Chemical
Dependency block grant
holders are – more and
more – going by the
wayside.**



***It's no longer
your grandpa's
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The shift to Managed Care and the new-style financial arrangements can be challenging for providers.

↳ **These new CONTRACT are prompting providers to seek new, additional funding streams so that they can be financially secure. All eggs in one basket is still not a good idea!**



↳ **What is different about FUNDING DECISIONS, i.e., who gets the Provider Contract?**

It's now a competitive field – NEW providers are coming into the mix, from the private sector. And ultimately, the Provider Agreements or expansion of such agreements may be awarded to the providers with BETTER OUTCOMES – rather than to the public sector organizations by default.

- **And sometimes the HMOs don't have to search very far to find new providers who are willing to earn their money one session at a time, and to be flexible and creative at the same time. (Sounds a lot like private practice, doesn't it? – This is one reason why practitioners in the private sector are well suited to this new health care approach.) Many new providers are now COMPETING for the business – and many 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 HMOs 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 HMOs 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.

And – most significant of all - the HMOs are shifting where and how the money is spent!

- **In managed care programs, the HMOs 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 HMO 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, and for clients!**



Yes, HMOs are looking for new providers AND services, if needed, as part of Cost Containment.

The HMOs 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 HMOs 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 HMOs re-
designing the delivery
system?



**Well . . . yes. More on
that in Module 201 of this
Course.**



But First Things First!

In order for providers to SAFELY deliver treatment under a Managed Care agreement, there are several CRUCIAL ISSUES AND TRENDS which providers should understand about managed care prior to jumping in. Like, 'how cold is the water?' This is true whether you are an individual practitioner or part of a provider network or are affiliated with a CMHC or Substance Abuse Treatment Program. And so we will first deal with 'What Is Meant By Capitation?' and 'Why Are MCOs at Risk?'

NOTE: Managed Care companies carry various labels - including Health Maintenance Organizations or HMOs, Managed Care Organizations or MCOs, Behavioral Health Organizations or BHOs, Health Insurance Exchanges, 'The Marketplace', etc. We shall generically refer to these as MCOs, unless there is a specific reason to differentiate.

So, is this course simply a 'business course' about paper and contracts? No. These new types of Managed Care contracts – and all of the clinical changes that go with them – are the key to continuing the treatment of your clients in this new health care environment.



'Capitation' and 'Risk'.

These two words form the basis of most managed care contracts between a State and an MCO. In most states, both CAPITATION and RISK are the keys to 'COST CONTAINMENT' (which is the same as 'CONTROL OF HEALTH CARE COSTS').



Most contracts between an MCO and the State carry with them some sort of RISK for the MCO. But at RISK for WHAT? The MCO is typically at RISK of losing money on the contract by the end of the year, if they don't control the cost of care well enough. Sometimes they lose a great deal of money!

A few states simply engage in an agreement with the MCO to control the amount of money spent on Behavioral Health Care – referred to as an 'Administrative Services Only' Managed Care Plan, or ASO. In that case, the MCO may not lose money, but it may lose its contract if it does not succeed in controlling the amount and type of services that providers deliver.



We think it's important to explain CAPITATION contracts, which approximately 75% of the States hold with MCOs for Behavioral Health programs such as Medicaid and the Children's Health Insurance Plan (CHIP).


But regardless of what type of Managed Care contract the MCO holds with the State, working with a managed care company involves major clinical and programmatic changes. This FlexiCourse 4A is hopefully a good introduction to what has changed here, and what providers need to do to survive the basics of Managed Care programs.



We'll now take a look at the most common form of State-HMO contracting in which the primary goal is the control of healthcare COSTS – RISK BASED CAPITATION.

'Capitation' – Understanding The Primary Method of Cost Containment



 **Capitation is a contracting method which may be used by States in public sector healthcare plans (such as Medicaid and Medicare) to arrange health care services for ALL of the health plan's enrollees, *through one or perhaps two big contractors*. The GOAL is to CONTROL THE TOTAL COST OF THE HEALTH CARE WITHIN THE STATE. The contractor that takes on this huge task is usually a managed care company (like an HMO), but sometimes a large provider organization such as a state-wide Community MHMR Center consortium or a large Substance Abuse Provider Network will take on the contract (although we do not recommend it).**

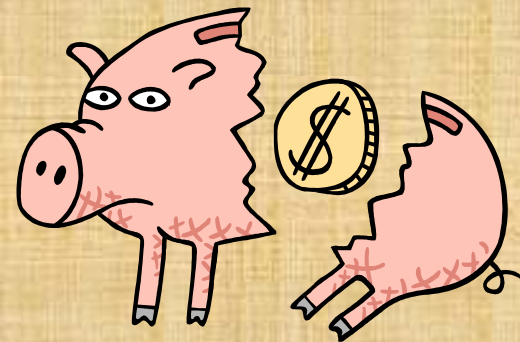
Capitation . . .



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 BHO. 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?

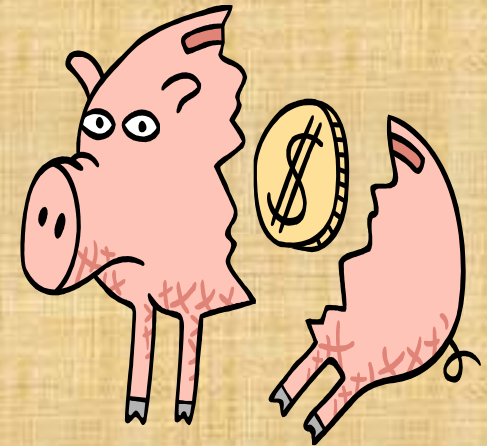
Capitation . . .

And . . . the 'AT-RISK' (capitated) entity (e.g., the HMO or other managed care company) must provide 'ADEQUATE, MEDICALLY NECESSARY TREATMENT' for ALL ENROLLED, ELIGIBLE consumers who present for services – no matter how many consumers appear for services, no matter how many times they present for care.



THIS IS A HIGH RISK RESPONSIBILITY! Will there be enough money, so that the HMO doesn't 'go in the hole'? Can the plan succeed?

These are the assumptions that make success possible:



1. We assume that only a **SMALL PERCENTAGE** of the total **ENROLLED** population will actually appear at the door for behavioral health services, and that . . .
2. . . . only a **SMALL PERCENTAGE** of those who **DO** actually seek services will require *intensive (expensive)* services.




If these assumptions are correct, and if the care is carefully managed by the HMO or other such contractor, the total 'capitation piggy bank' will hopefully 'stretch' to meet all the needs during the contract year.

**Does it always work? NO.
Sometimes the HMO runs out of
money.**


**The real danger here, for HMOs and other
such health plans: If the total COST of
care provided to the enrolled population is
more than the contract PAYS, then the
HMO contractor will probably fail. This is
what we mean when we say 'the
contractor is AT RISK'. At risk of what?
'AT RISK of losing a great deal of money.'**

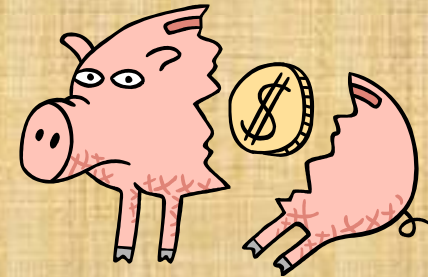


Capitation . . .


 **Note: Sometimes the State underestimates or miscalculates how many enrolled individuals are going to actually appear at the door for services.**



 **If because of such a miscalculation or for some other reason the total contracted funds do NOT stretch to last the entire year, the HMO or other such contractor may well lose money or 'go broke', regardless of how well they 'manage the care'. This is the main reason that this is a 'HIGH RISK' arrangement for an HMO or other contractor to enter into.**




Capitation – A Cash Cow?

 Sometimes **PROVIDERS** think that a lot of money might be made this way, if the provider organization takes over the managed care contract itself, instead of an HMO doing it. Are they correct? Well, yes and no. We have to remember that no matter how well managed a contract is, the risks are still great with **ANY** true capitation contract . . . for all of the reasons we mention in this course. The financial losses can be **HUGE!** Therefore, even **LARGE** provider organizations must be extremely wary of taking on such high risk 'capitation' or 'sub-capitation' contracts, even if they are tempted to do it – and even if they have the \$2 million or so that typically must be placed in the form of a 'bond' with the state treasury, before accepting the contract.



Capitation . . .

 **CEU By Net!** believes that this type of full-risk capitation contract is generally **NOT WORKABLE FOR TREATMENT PROVIDERS** to take on (as the primary risk holder), no matter how 'big' the provider is. We believe that true capitation contracts are potentially 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. How can they possibly make this work – from a practical perspective? We'll look at that in the next lesson.



Ok, but what about PROVIDERS – what's this talk about we being 'AT RISK'? And what about our OPPORTUNITIES?

The first part of this course looked at WHY the MCO is at great risk of losing money with these new managed care contracts. We needed to understand the RISK that the MCO is taking, in order to understand some of the things that they do. And we will also, throughout this course, show ways that PROVIDERS take on some risk as well – usually of a different nature than that of the MCO, but sometimes similar, on a smaller scale. In Module 201, we also will make a point that MCOs sometimes push providers into taking on more RISK than is wise. And yes – we will get to some great OPPORTUNITIES for providers, very soon.



To access Part B of Lesson 1, simply close this window (this lesson) to return to your list of Study Guides and Quizzes. If you want to return to the site's Lessons and Quizzes later: Log in, which will take you to you're My Home Page. Click on your course, and you will be on your Study Guides and Quizzes page. Click on Lesson 1B of Module 101, Course 4A.