Course 5A – Module 201

Lesson Three of Module 201

More on Issues and Options For Providers – and How The Delivery System Is Changing!

Includes the Four Core Clinical Principles Used By Care Managers, to Determine APPROVAL vs. DENIAL OF TREATMENT Requests.

In the previous Module 101, we asked if this shift in healthcare means what it sounds like . . . that the HMOs are re-designing the service delivery system.

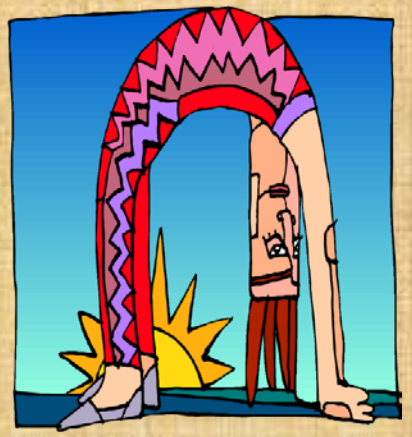
Well . . . yes. In fact they are.

And does this affect behavioral health providers? As we have seen, it certainly does – and it's NOT all bad! In the previous lesson, we saw some of the ways that providers can benefit – new ways to deliver treatment under Medicaid and other such managed care plans . . . options such as CASE RATES.

Such specialized services will reduce the need for more expensive services. Such non-traditional services – part of the REDESIGN OF THE DELIVERY SYSTEM - will ensure that there are services which can DIVERT highly recidivistic patients from UNNECESSARY re-admission to the more costly levels of inpatient care.

But Case Rates are not all that is needed. There must be intensive home based services, detox units, Intensive Outpatient Programs, intensive case management, and so forth. Offering such 'DIVERSIONARY' and 'STEP-DOWN' services is – as we have emphasized in this course – one way that the managed care company can CONTROL its COSTS (i.e., its expenses). NOTE: **It is important to understand that such contract options may not surface until a few months into the State Plan rollout – after the need is known.**

As we have indicated previously, the managed care company's decisions may 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 more expensive levels of care. How? The HMO may 'step them down' to a lower level of care (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', PROVIDED THAT EFFECTIVE ALTERNATIVE PROGRAMS are available through the HMO's coverage.



Alternatives to traditional treatment

- **Even if the provider is opposed to the HMO's practice of 'stepping the consumer down' to lower levels of care, it is important that he be willing to work with the ALTERNATIVE APPROACHES TO TREATMENT which are promoted by many managed care companies and will likely be made available within the network.**

Alternatives . . .

- **As many (or most) of us know, over the past few years, programs have been re-designed with good results. Some of the best programs emphasize community based treatment alternatives which teach SKILLS to effectively deal with symptoms and to live and work successfully within the community. Even in 'commercial' managed care plans, long term 'talk therapies' have given way to a briefer, more COGNITIVE AND BEHAVIORAL approach to anxiety and depression.**

This is not new to most of us. But what MAY be new to many is that we must document these activities in a much more specific way than we have in the past, if we want to be paid. More on this at the end of this lesson.

Flexibility In Programming Can Be Painful to Some – Even Boards of Directors.

Under Managed Care, program design often takes new twists that are unfamiliar to some professionals and Boards of Directors. Like what? Programs such as Intensive In-Home Services, out-of-office service delivery . . . true 24 hour availability and the need to extend telephonic response to 'around the clock' . Some Boards of Directors are fearful of the inherent legal liability of out-of-office services. And we also see new requirements that can be irksome . . . such as the need to pass through some sort of external Utilization Review (UR – or 'CARE MANAGEMENT') to obtain permission to treat the client . . . having to play 'Mother May I?' with the MCO. These are major issues to the uninitiated.

Non-Traditional Program Design Mandates – It's the Best of Managed Care

- **We want to emphasize that the 'best' managed care plans EMPHASIZE CREATIVITY in program design, crisis intervention, out-of-the-office services, and 'step-down' services (services of less intensity that allow safe movement from more intensive services).**
- **Public Sector Managed Care ALLOWS DEPARTURE from standard services such as routine outpatient and inpatient – includes psychosocial rehab for mental health clients and departure from 'set' ASAM treatment protocols for CD providers.**
- **The best plans emphasize preventative and 'least-restrictive', NON-TRADITIONAL ALTERNATIVES to inpatient and partial hospital or inpatient detox.**

Non-Traditional Programs . . .

- **Emphasizes in-home services and other community-based interventions, and ENCOURAGES specialized diversionary services (those which divert a consumer from an unnecessary admission to a costly and intensive level of care) – including 'wrap-around' services, mobile crisis teams, 23 hour observation for both MH and CD consumers, and transitional step-down units.**

- **Recognizes dual diagnosis issues, unbundles ASAM criteria for CD – which can be a 'positive' for CD**

- **Capitalizes on "bang for the buck" as well as being GOOD for many or most clients.**

Overall Effect of Managed Care On Behavioral Health Services, For Providers

- **There will be decreased availability of Federal block grant-type funding and annual State and local contracts – these will diminish as a result of shifts to a managed system of care**

- **Providers must seek out new, diversified funding sources so that 'all eggs are NOT in one basket' – essential for survival!**

- **There is increased need for diversity of products, market share, flexibility, creativity, good *outcomes***

- ***Providers must expand their horizons and must start to function more like a business!***

. . . Effect On Services, for Providers

- **We must be willing to change up our programmatic or clinical game as needed, and agencies may need to re-examine organizational practices. We may need to explore new ways to 'get there' in terms of rising to the occasion of managed care – especially in program and practice design.**

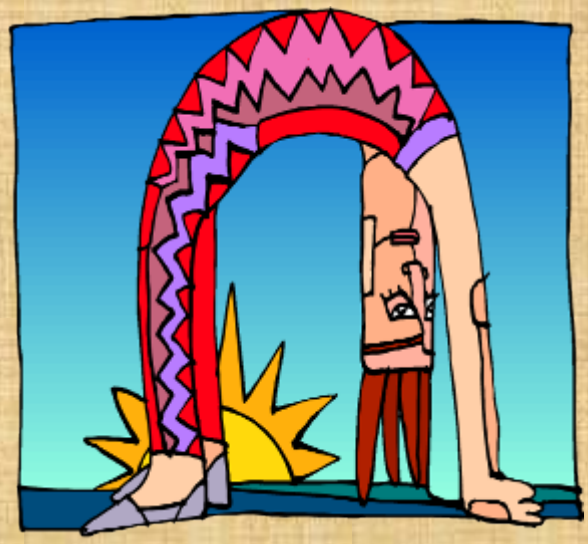
Managed Care Companies expect for agencies to have ample access to professionally licensed staff (as opposed to unlicensed MA and BA levels). There is also a need for rigorous documentation of treatment services, with a strong 'clinical' orientation – which may be noxious to some.

The Effect On Services . . .

- **We must be CREATIVE and FLEXIBLE, and willing to modify program designs. We must live with shorter lengths of stay, and we need to expand or tout our non-traditional services.**

- **All these requirements are sometimes hard on agency staff – and clients must adjust to new models, too!**

- **Need to COLLABORATE, COORDINATE and partner with other providers to survive the shifts and to look for economies, new ideas, and more!**



Which Means . . .

Productivity and effectiveness are the watchwords – "doing good" is no longer enough

Higher 'productivity expectations' for staff and all providers is a priority – now as never before!

Resting on your traditional laurels will 'do you in'

Both the client and the provider must 'come out of the cocoon' which has served most of us well all these years – non-traditional services are oftentimes GREAT for clients!

Providers partnering together produce unbeatable results!

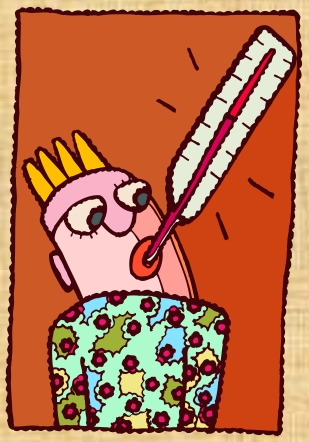
And . . .

- *Professional sloth is out . . .*
- *Business-mindedness is in!*
- *Professional myopia is out . . .*
- *Business smart is in!*
- *Doing it the 'old way' is out!*
- *Business creativity is IN!*

The State's Responsibility to Educate

Before they make the shift to managed care, States should ensure that these things happen:

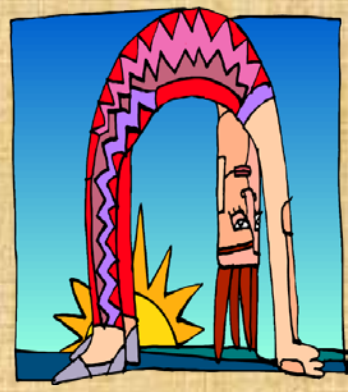
- **Intensive training of providers on managed systems of care, with small managed care-related pilots**
- **Consideration of 'shadow billing' pilots, where providers do mock-up billings, 'earning one dollar at a time' for what they deliver, instead of relying on those fixed dollar contracts like Block Grant or annual State contracts.**
- **Consultative support to providers regarding diversification of funding streams (away from 'all the eggs in one basket')**



A CARE MANAGEMENT OVERVIEW:

For mental health consumers, remember that Managed Care Companies 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.

And for the CD client, they 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.



- **IMPORTANT REMINDER: Is the managed care company telling you that you CANNOT provide the services which you believe the client needs? NO. A provider is *always* free to deliver any service to a patient according to the provider's own professional judgment or organizational philosophy. HOWEVER – if the managed care company does not feel that the services are MEDICALLY NECESSARY and ESSENTIAL for the stabilization of the patient (or if the health plan simply does not cover a certain service or limits how much can be provided), then you WILL NOT BE PAID by the managed care company to provide the service. You will have to do it for free ('pro bono'), or will have to use other funds to cover the cost.**

What's the reward if you decide to 'play the managed care game'? Those providers who are willing to 'think outside the box' – creatively – may get a major share of the business! This is one thing that makes contracting with HMOs so interesting – it's a whole new ball game!

This new trend applies to ALL providers, even those who have traditionally done most of the work in this field up until now: You can believe it – traditional providers no longer have a 'lock on the business'.

And even those providers who join the shift to managed care need to diversify (expand) their funding sources! Don't put all your eggs in one basket – even if you have a good contract with an HMO!

Diversify Your Funding Stream!

Diversification . . . and other cautions!

- **Providers are wise to diversify their source of income (their 'funding base') because 'putting all our eggs in one basket' is dangerous. This is especially true for those who have always relied upon block-grant type contracts, which are decreasing or going away as managed care moves into states.**
- **For state governments: They need to 'go slow, go slow, go slow'. Haste can be damaging and counterproductive.**
- **For the fearful: We cannot stop the 'managed care train', although 'some routes may be discontinued' as states experiment with various designs of managed care. Some designs are better than others!**

Final Notes for This Module . . .
Including a Fast Review of How Care Management Works – and Its Impact on How You Document Treatment In Your Clients' Records

Access-to-Treatment Issues

- **The goal of Managed Care is to ensure that the consumer receives**
  - **the right treatment**
  - **at the right intensity**
  - **for the right amount of time**

- **Managed Care moves treatment decisions (like admission and continued stay) out of the hands of the provider, to a higher level of review. This reality is viewed by some as causing treatment to be 'less accessible'.**

- **Almost always, managed care <u>does ensure</u> rapid initial services, convenience, no waiting lists.**

The 'simple' access issues:

- **Access must extend *beyond* the 800 number, into the inner city or other high-density ethnic areas, and into the rural areas, with culturally relevant providers.**

HMOs and BHOs must heavily involve stakeholders including advocates and consumers. They will regret it if they don't.

- **Keep it simple. Providers should not have to jump through hoops to get in touch with the Care Manager, and the consumer should be able to quickly contact the provider.**

But …. is there always better *access* in Managed Care Systems? Some believe that there may be significant access issues, related to 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 and access to important services.**

- **In fact, quality will probably suffer if the State cuts back the amount of money that it CURRENTLY spends on healthcare!**

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

Recall from an Earlier Lesson, the Concerns of the National Alliance for the Mentally Ill (NAMI) About The 'Cost Control' Element

The National Alliance for the Mentally Ill (NAMI) has consistently expressed concerns that the emphasis will 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 most recently expressed in 'Grading the States 2006: A Report on America's Health Care System for Serious Mental Illness.' This statement and others like it were made in this year's 2006 NAMI Report: "Managed care models sometimes turn into managed cost models."

And the CD Issue Related to Care Management Decisions . . .

And recall the special note about CD: Standardized Level of Care protocols (such as those typically used by the HMOs, BHO, MCOs) are believed by many to result in questionable clinical outcomes for chemically dependent consumers. Reason: These protocols may not adequately accommodate the CD population's inherent tendency to relapse repeatedly while they are on the road to recovery. What to do here? Encourage your state and HMO to engage in good Quality Management studies of outcomes for CD patients – and sufficient FUNDING! And for your most relapse-prone clients – especially those who 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'.

So what is the real issue here? The need for the contract manager to CONTROL COSTS may result in a DENIAL OF CARE for your MH or CD client . . . i.e., refusal of the insurance company (HMO, MCO, other) to approve the services for your client that you have requested.

For Both Mental Health and Chemical Dependency Services, 'Medical Necessity', 'Level of Care' and 'YOUR Documentation of the Need For Treatment' Are Connected!

Why Documentation Style Is Crucial to Managed Care Success

- **Remember that Managed Care programs are 'not your same old' Block Grant or State Revenue Program – the HMO 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.**

Your documentation of the treatment you do must clearly support this level of specificity.

Learning How to Document Is The Key To Obtaining Appropriate 'Levels of Care' . . . and to Keeping Your Money When You Are Audited! And It Often Collides With Our ETHICS About What Is Appropriate To Say and Share About a Client In His Record.

- **You must think about your client's treatment in the same way that the HMO's Care Manager is thinking when he or she reviews the case: "WHY should the HMO spend 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!**

(Re)Training, Culling, New Hiring Is Often Needed!

- **This type of work is not 'for everyone'. It is irksome to some. Impossible for others. Some may not be able to justify, in their own minds, the need to be more forthright in their documentation about the client and his weaknesses and illness.**

- **(Re)Training, culling, and some new hiring approaches are often necessary, in order to get the right staff who can rise to the occasion. (But we think that *most providers can in fact rise to the occasion – and they can do it ethically!)***

The Core Concepts Behind Level of Care and Approval of Treatment

Managed Care plans approve or deny treatment based upon some CORE CONCEPTS related to LEVEL OF CARE (LOC) – and we are going to look at the four Core Concepts here.

EVERYTHING that we write in a client's treatment record (chart) needs to be guided by these concepts. Why? Because what we write in the record SUPPORTS THE AUTHORIZATION that we obtained, and demonstrates that we did in fact DO THE TREATMENT which was authorized.

One purpose of this course is for providers to understand that they CAN comply with these requirements within ETHICAL BOUNDARIES.

The Four Core Concepts of Care Management – Yes, They Also Shape How We Document Treatment

The four core concepts that follow are dear to the heart of the HMO or other insurance company, and they determine whether they approve a treatment request or not. Obviously, these concepts should shape our approach to documentation within the client's treatment record (chart).

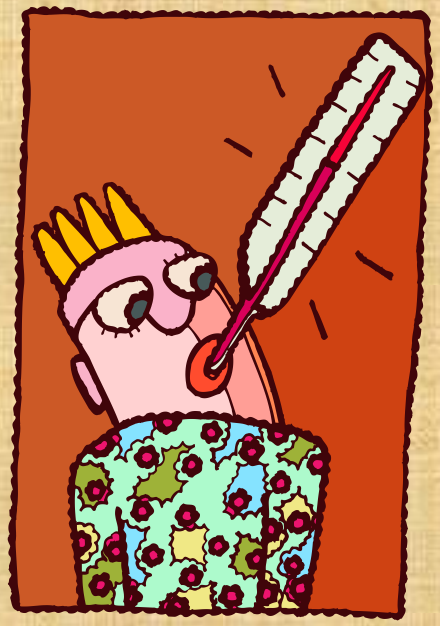
If we will adhere to these concepts when we write in a chart, we will ensure that we and the HMO are 'on the same page'. This is crucial, when the HMO's auditors come to pay us (AND our treatment records) a visit!

1. Medical Necessity

THE CORE CONCEPTS Of Care Management

1. It must be CLEAR that the treatment (the Level of Care or LOC) which is approved is MEDICALLY NECESSARY. Medical necessity is defined differently in every state. But these are some of the criteria that are quite common, in determining MEDICAL NECESSITY. The proposed treatments . . .

- **are REASONABLE AND NECESSARY in order to diagnosis or treat a specific mental health or chemical dependency disorder;**
- **are needed to IMPROVE OR TO MAINTAIN or to prevent deterioration of functioning resulting from the disorder;**
- **are in accord with PROFESSIONALLY ACCEPTED clinical guidelines and standards of practice for behavioral health care; and**



- **are the most appropriate level or supply of service which can SAFELY be provided; and**
- **are furnished in the most appropriate and LEAST RESTRICTIVE setting in which services can be safely provided; and**
- **could not be omitted without ADVERSELY AFFECTING the Member's mental and/or physical health or the quality of care rendered, AND**
- **there is a REASONABLE EXPECTATION that the treatment will result in PROGRESS.**

2. Functionality – It's Primary

- **The diagnosis is important – BUT diagnosis alone will not justify a particular treatment. WHY? It is the patient's FUNCTIONALITY that is the most important, when deciding if a particular treatment is needed, and for how long. For example, an individual may have a diagnosis of Bipolar Disorder (and may have been hospitalized many times in the past) . . . but is now stabilized on medication, is back to work, is relating well to family and friends and co-workers, and is otherwise no longer a danger to himself or others. Does this individual continue to need intensive services? NO.**

- **On the other hand, e.g., if an individual is struggling with maintaining a job, is having acute symptoms of a disorder, is perhaps at risk of inpatient admission, and/or is having major difficulty with everyday functionality, then intensive treatment may well be considered MEDICALLY NECESSARY.**

3. Treatment Goals and Interventions – Must Match the Functional Deficits & the Diagnosis

When treatment is authorized, it is not a 'free pass' to do whatever the provider wants to do. The managed care company is authorizing a SPECIFIC SERVICE. And that is the only service for which we can submit a CLAIM FOR PAYMENT.

As to the DETAILS of how we provide the service, everything we do must address the major FUNCTIONAL ISSUES that we identified in the assessment, and for which we obtained the authorization to provide treatment.

And we CANNOT IGNORE A DIAGNOSIS! For example, if a consumer is depressed AND is also using or abusing DRUGS or alcohol, we MUST ADDRESS the substance abuse or dependency in the treatment plan and in the services we provide.

4. Progress – It's Essential If We Are to Continue Treatment

Managed Care cannot pour limited resources down the drain! Therefore, the HMO looks for PROGRESS being made, when we approach them to authorize more care. If a consumer is NOT RESPONDING to an approved service – i.e., if he is NOT MAKING PROGRESS, then we must . . .

. . . take a close DOCUMENTED look at what needs to be changed, AND THEN

- **make significant CHANGES IN THE ITP – what we are doing with the consumer, and perhaps even**
- **REQUEST CHANGES IN THE AUTHORIZED SERVICE.**

NOTE: If the individual FAILS TO BENEFIT from the treatment that is available to him, and has not benefited from revised plans of care, then the HMO may ultimately make a decision to move to a 'maintenance' regimen that seeks to keep the individual basically stable and out of danger. Goals to move the individual forward with significant progress may be abandoned, if it is clear that he has reached a 'plateau'. A PLATEAU means that it is unlikely that he is going to make additional progress regardless of what interventions are applied.

Will no one save us?

- **Whining and fear will not stop this Managed Care train, particularly for Medicaid and other publicly funded programs.**
- **Politics and State budgets will take a back seat to provider preferences.**
- **Politicians are ultimately ruled by fiscal realities, despite old friendships and loyalties.**
- **Contract "reform" is the norm – just like big business!**
- **Those providers with flexibility, creativity, and courage to change will 'win out'. The rest will be left by the tracks.**

No.

Medicaid Managed Care, likely here to stay. This is a quote from 2002. This is many years later, and yes, it's still here.

"In the past decade, state and federal lawmakers have increasingly recognized the value of managed care to the Medicaid program's long-term stability and sustainability. In 2000, Medicaid managed care organizations covered 14.2 million beneficiaries, or 42 percent of the total Medicaid population, up sharply from 9 million in 1995. Every day, in communities across the nation, health plans are making a crucial difference for the millions of Americans who depend on Medicaid managed care programs for their health security."

- Mr. Charles Milligan, The Lewin Group, in a February 2002 report by the American Association of Health Plans

With the coming of the Affordable Care Act (ACA) we know it's unlikely that anyone will save us from Managed Care – whether we are talking about Medicaid or the ACA or another State or Federal behavioral health plan. BUT learning more about 'Care Management' – and how to deal with it effectively – can make things so much easier! We discuss Care Management in <u>more detail</u> in Courses 2B and 2C.

Congratulations!

You have completed the 3rd lesson in Module 201.

You must pass Quizzes 1, 2, and 3 for Module 201, and must complete our short Feedback form for Module 201, to receive your CE Certificate for Module 201.

To reach the links for the quizzes and the feedback form, simply close this page and you will return to My Home Page. Or return at another time, log in, and follow the links to your Study Guides and Quizzes page.

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