

**This MiniCourse
Earns 2(or .2)
CE Credit**



Understanding that Managed Care 'Capitation Thing' and HOW It Impacts Providers!

**Intro to Clinical and Program Implications & Options
For Providers**

Lesson 1



What Are the Primary Goals of Managed 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**
- **Yes! *Control the cost of healthcare!***




OK – but WHY are they doing this?


What are they REALLY trying to accomplish with Cost Containment?

Trying to accomplish . . .

The designers of the new public sector managed care plan 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!

'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 medical and behavioral health funds are making some serious changes in how they spend the money – whether it's a publicly funded plan like the Affordable Care Act, or a private commercial or self-insured plan. 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 to this day, 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.)

Is the 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.**

HOW are these 'Cost Containment Goals' being approached?

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

- There is a need to obtain **PRE-AUTHORIZATION** (i.e., pre-approval by the MCO or other ACA Marketplace Health Insurance 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. And they may not get what they ask for.





... And the healthcare money is changing hands!

Yes, the MONEY IS CHANGING HANDS! Managed Care companies (generically referred to as 'MCOs' – which include HMOs, BHOs, and other large 'Marketplace' organizations who are contracted to administer healthcare programs) are now holding the 'money bag' in many states, instead of the State or a local governmental agency managing the healthcare funds themselves.

This is where CAPITATION and SUB-CAPITATION contracts enter the picture!

This trend may also apply to management of 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 Community Mental Health Centers and CD Treatment Providers to deliver services to the indigent.

... And along with this change, 'Provider Contracts' are changing, too!



***It's no longer
your grandpa's
Chevy!***

- **Watch for the NEW WAYS OF CONTRACTING WITH PROVIDERS . . . such as fewer dependable, annual contracts with traditional not-for-profit providers like Community MHMR Centers and Substance Abuse Consortiums – and more contracts with providers FROM ALL SECTORS including the 'for profits' – all vying for contracts. Also watch for trend toward the newly dubbed 'NARROW NETWORKS' – where consumers have very few options to choose from, to deliver their care.**



In public contracts, several years ago, a switch was made in how behavioral health funds were contracted out. Instead of an 'open ended, flat rate contract' to simply 'provide services' (with some basic expectation for 'how much service and how many people' tacked on), the system began to switch over to FEE-FOR-SERVICE contracts . . . where you got paid only for what you actually DID. There were even some 'case rates' thrown in which gave us a flat rate for all Mental Health or AOD services delivered to a particular client during a week, a month, or more.

And now with the arrival of the Affordable Care Act, the reimbursement scenarios may be moving AGAIN, to a form of 'bundled' rates – where several providers on both sides of the health care fence (physical medicine and behavioral health) SHARE a flat rate payment for delivery of ALL care the client receives – whether that's medical care for physical problems or behavioral health problems. This would be an ultimate form of cost control – and pilot programs are now in the works.

You will understand why health care contracts are being designed in this way (wanting more for less so to speak), if you understand CAPITATION contracts – the main way that many States AND the Feds now contract with health care insurance organizations, in order to control the cost of health care.


‘Does this mean what it sounds like? Are providers in for some very unsettling times?’

Well, yes. We are now boarding a new type of roller coaster.



‘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, Medicare, and the ACA) 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 AND THE COUNTRY**. Contractors who take on these huge tasks are usually a managed care company (like an MCO), 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).

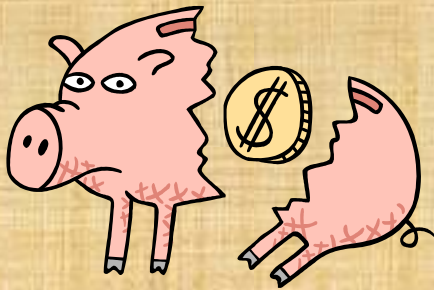
Capitation . . .



In true CAPITATION, the State pays the MCO 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 MCO 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?

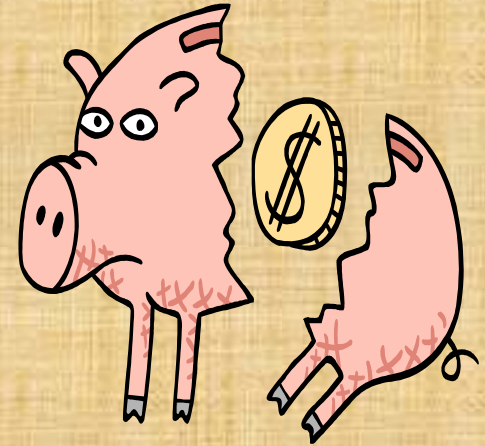
Capitation . . .

And . . . the 'AT-RISK' (capitated) entity (e.g., the MCO 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 MCO 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 MCO 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 MCO runs out of
money.**


The real danger here, for MCOs and other such health plans: If the total COST of care provided to the enrolled population is more than the contract PAYS, then the MCO 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.'

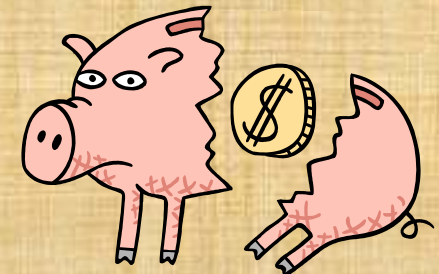


Capitation . . .


 **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 MCO 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 MCO 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 MCO 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 . . .

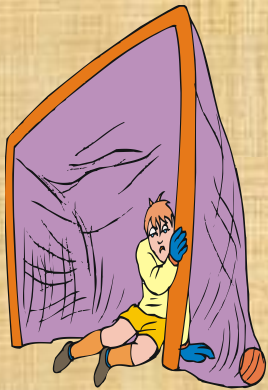


 **CEU By Net!** believes that this type of full-risk capitation contract is generally **NOT WORKABLE FOR TREATMENT PROVIDERS** to take on (as the primary risk holder), no matter how 'big' the provider is. We believe that true capitation contracts are potentially safe and workable *only* for big companies with millions of dollars held in reserve to cover potential losses – and even then, some MCOs will and do lose money.

So what is the PRIMARY METHOD that the managed care companies use, to avoid losing money on the contract?

IT'S CALLED CARE MANAGEMENT – OR UTILIZATION MANAGEMENT!

The 'at risk' entity (MCO or other) MUST carefully CONTROL AND MANAGE the use of the various services that are available to the enrollees (members)! And IF they don't MANAGE AND LIMIT THE CARE that is delivered by providers, they will lose a great deal of money by the end of the year! That's why they call it 'Managed Care'!



This is one of the hardest things for providers to deal with in managed care. Why? Because they must give up their control, in determining what treatment their clients receive. You can learn more about this process – and how providers can deal with it – in Course 2B. We give a good overview of how the MCOs make Care Management decisions. We also look at the details of how your documentation in treatment records may need to change, so that you can more easily obtain authorization to treat your clients, and can 'keep your money' after they audit your charts (i.e., avoid recoupment).

Care Management! Hold On To Your Thermometer!

OK, but in general, how's it work? The MCO will authorize **ONLY** the care that is **ABSOLUTELY NECESSARY** – i.e., only the care that is 'medically necessary'. They decide if the patient is 'sick enough' to receive a certain treatment, and if so, for how long. There are also such factors as 'is he making any progress?' that come into play here. And is the treatment viewed as appropriate for the diagnosis?

Generally speaking, under Managed Care Plans, providers no longer have the freedom to delivery care 'at will' – at least not if they want to be paid for the care they deliver.






Summary Statement: For mental health consumers, MCOs DO NOT look simply at whether or not it would be 'helpful' or 'nice' for the individual to have a certain type of treatment, or whether the patient simply 'wants it'. And they DO NOT base decisions upon a plea that 'we have always done it this way.' Many of the 'old ways' have been discarded or radically modified, in this day of 'short funds' and more rigorous management of treatment. Who gets treatment has also changed.

For the CD client, MCOs DO NOT look simply at whether or not he or she is having an alcohol or drug related crisis, or whether or not he has experienced a recent relapse, in order to say 'OK' to a treatment request. And they DO NOT base decisions upon a plea that 'we have always done it this way.' In fact, if the client has had multiple relapses to use of alcohol or drugs despite treatment, they may begin to question whether additional treatment beyond detox and basic services is really justified. Here too, who gets treatment has changed.

- **IMPORTANT NOTE:** 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.



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

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



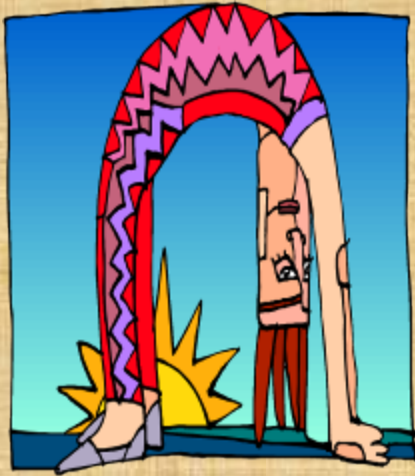
But is the news **ALL BAD?** No.

Actually . . . Opportunity Knocks! The MCOs Are Also Shifting Where and How the Money Is Spent

- **In managed care programs, the MCOs CAN SHIFT where the funds are currently being spent – and we can oftentimes do it with better outcomes! This is one of the best features of managed care.**
- **How does this work? The MCO can *shift* some of 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!**



Providers can benefit from this shift!



- **COMMUNITY PROVIDERS** can support this new way of spending funds by ‘thinking outside of the box’ – whether we are a private practitioner, or a State Hospital, or a not-for-profit agency, or a Substance Abuse provider network, or a CMHC! Flexibility and innovation are **IN!**

- Providers can re-design and/or enhance the services that they provide – in order to ensure that creative, non-traditional services are available. These services will help the managed care company to **PREVENT UNNECESSARY** admission of patients to the most expensive levels of care. And it can be **GOOD** for consumers, too!



In Summary, Capitation Can Work IF . . .

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



- 📁 **The State's or Fed's original predictions MUST hold true . . . about the COST of services, and how MANY enrollees will actually seek services, and what KIND of services will be needed, and how MUCH, and**
- 📁 **The FUNDS ALLOCATED to the program MUST BE adequate and must be carefully managed!**

. . . with a caveat . . .

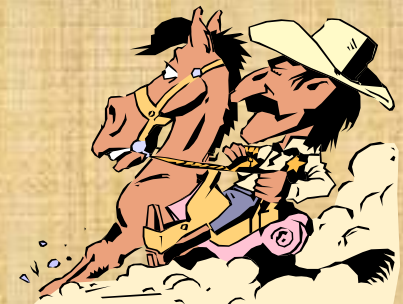
EVEN SO . . . we want to be clear that NOT ALL forms of CAPITATION are workable or desirable (in our opinion) EVEN WHEN those 2 conditions are met.



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

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

What are we talking about? SUB-CAPITATION, coming up in Lesson 2 of this course.!



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



Congratulations!

You have completed Lesson 1 of Course 1C. You may complete the short quiz for this lesson either now or later. To reach the links for the quizzes and the lessons, simply close this page. You will be returned to 'My Home Page', and from there you'll find your list of Study Guides and Quizzes.

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 by moving on to Lesson 2 – your choice!