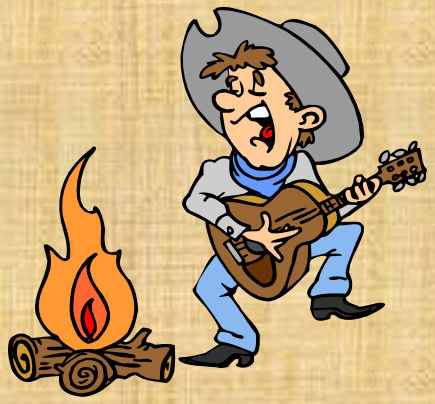
Welcome to Course 3A

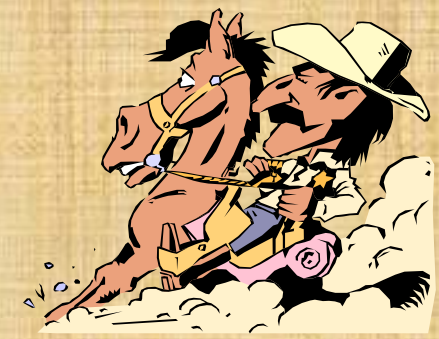
‘Managed Care – Is There Anything GOOD About It?’

a.k.a., The Good, The Bad, and The Ugly of Providing Treatment Under Managed Care – The Perils and The Opportunities!



Course 3A

Lesson 1



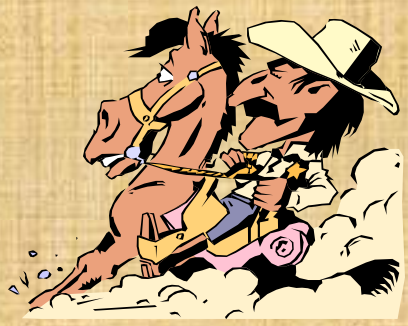
Understanding ‘Capitation Contracts’ and How It’s Done

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

'The Bad'

CAPITATION is the main way that States control cost of programs like Medicaid and Medicare. And we believe 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! But first, let's look at a straight CAPITATION contract. What IS that?



'The Ugly'

‘Capitation’ – Understanding The Primary Method of Cost Containment

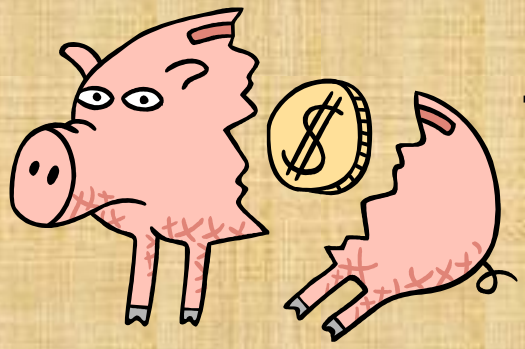
- **Capitation is a contracting method which may be used by States in public sector healthcare plans (such as Medicaid and Medicare) to arrange health care services for ALL of the health plan’s enrollees, *through one or perhaps two big contractors.* The GOAL is to CONTROL THE TOTAL COST OF THE HEALTH 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?

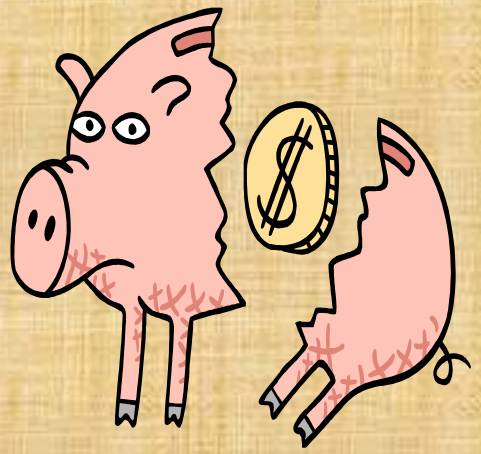
Capitation . . .

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.**

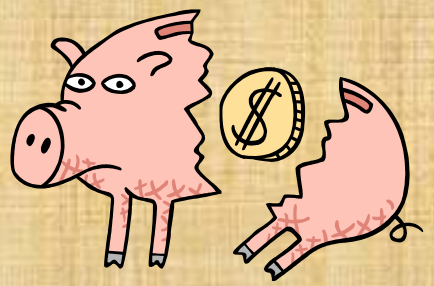
Does it always work? NO. Sometimes the HMO runs out of money.

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.**



SO THEN … HOW DO THE BIG COMPANIES SURVIVE? THEY ENGAGE IN 'CARE MANAGEMENT'!

What's Care Management? The 'at risk' entity (HMO or other) MUST carefully CONTROL AND MANAGE the use of the various services that are available to the enrollees (members)!

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'!

How 'Care Management' Works . . .

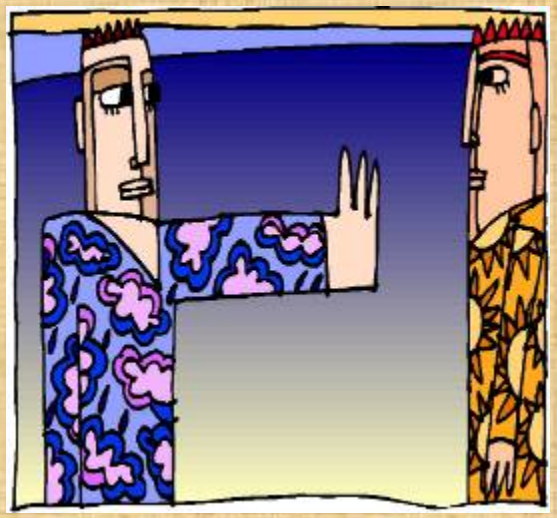
How's it work? The HMO will authorize ONLY the care that is ABSOLUTELY NECESSARY – i.e., only the care that is 'medically necessary'. They decide if the patient is 'sick enough' to receive a certain treatment. Providers no longer have the freedom to delivery care 'at will' – at least not if they want to be paid for the care they deliver.

When dealing with Behavioral Health (Mental Health, Substance Abuse, Chemical Dependency, or Dual Diagnoses), we are NOT talking about being 'physically sick' as in pneumonia or appendicitis. We are talking about mental and behavioral functionality, and safety for self and others. Treatment of these MH and CD diseases can be very expensive!

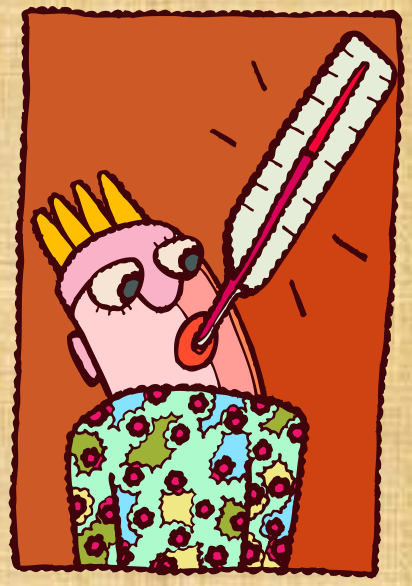
A Couple of HMO Cost Control Strategies

- **Especially if money for behavioral health is tight, the State and the HMO may control the cost of care by REDUCING THE NUMBER of people the HMO treats with 'high-end' (expensive) services.**

- **How? The CRITERIA that make an ENROLLED person actually 'ELIGIBLE' for certain costly services can be restricted– so that NOT EVERY enrolled individual will be *eligible* for EVERY service. For example, *unless* a patient has a particular DIAGNOSIS, he may be eligible for *very few services*. Or, UNLESS his social and behavioral DYSFUNCTION is chronic and severe, he may not receive services from the healthcare plan at all, after assessment.**



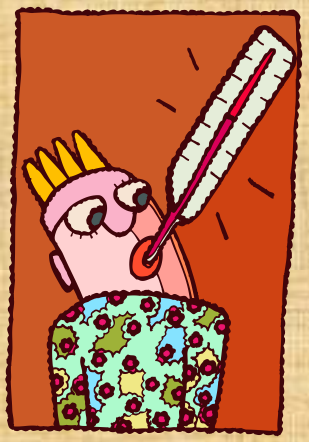
The 'worried well' and the 'early stage' drug or alcohol user are disappearing from the Managed Care treatment scene, as money grows tighter.



Cost Control Strategies . . . Here To Stay!

Regardless of our feelings about this approach, it is clear that the 'AT RISK' HMO MUST BE VERY CONSERVATIVE in how its contract dollars are doled out to providers, so that the funds will STRETCH to cover the entire year.

What do we mean – 'conservative'? Again, simply this: Under managed care, the HMO will authorize ONLY the care that is ABSOLUTELY NECESSARY – i.e., only the care that is 'medically necessary'. This is the MAIN FORM of cost containment. 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 of Care Management: For mental health consumers, HMOs 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.

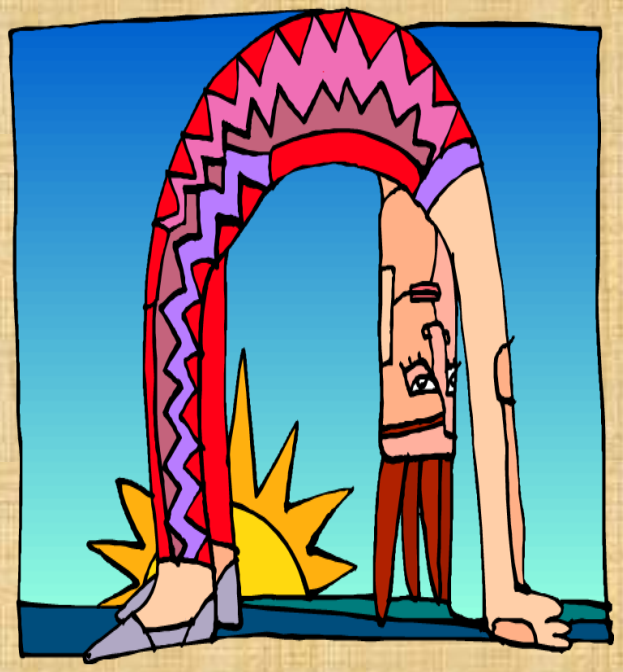
For the CD client, HMOs DO NOT look simply at whether or not he or she is having an alcohol or drug related crisis, or whether or not he has experienced a recent relapse, in order to say 'OK' to a treatment request. And they DO NOT base decisions upon a plea that 'we have always done it this way.' In 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.

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

- **The money placed in the care of HMOs and other such managed care companies is typically rather limited, because State legislators are trying to control the cost of health care. Thus the HMO must do what it can to reduce how much money is spent on treatment. In other words, they must PRIORITIZE who gets treatment, and what they get, and for how long! And that requires some adjustment on our part.**

It is true that the managed care company's decisions may sometimes 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 expensive levels of care. How do they limit this? The HMO may 'step them down' to a lower level of care (i.e., 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'.



FREQUENT QUESTION: But do HMOs just cruise through their contract – getting out of one thing after another? Providing little care to persons who are really sick? Typically, the answer to that is NO. The feds and the States will not allow it. And if the HMO allows patients to deteriorate from lack of good treatment, the resulting cost of excessive inpatient care 'does them in', financially.

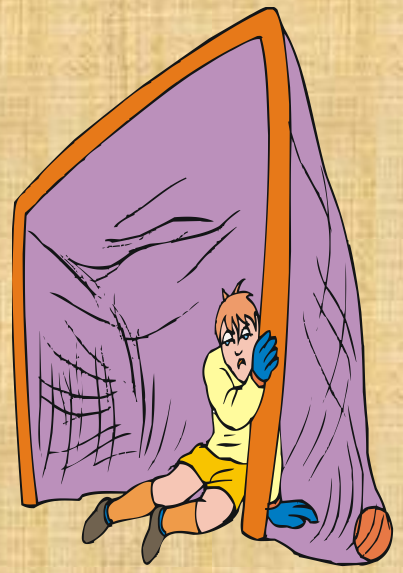
Yes, HMOs do need to carefully managed the care. And this can be painful to providers and to consumers alike. But the process of determining MEDICAL NECESSITY is indeed the KEY to COST CONTAINMENT - especially for a state that is struggling to control and manage its health care costs. That's why they call it 'Managed Care.'

Will all be rosy if the provider cooperates?

NO. Managed care participation can be challenging all the way around. We talk about this in detail in Course 5B – 'Where the Rubber Meets The Road', which earns 5 or .5 CE Credits.

Ok, but what kind of issues might providers encounter? Occasionally managed care companies engage in practices that are at best manipulative – intended to regulate their CASH FLOW on a daily basis. Like what? Like delaying the pay-out of treatment dollars, even though they do indeed eventually pay the provider all that is coming to him. And, like BENCHING which we describe momentarily.

Cost control . . .



CASH FLOW CONTROL: HMOs are occasionally known to use strategic methods to control their immediate day-to-day CASH FLOW, particularly near the end of the month or the end of a fiscal quarter. This is perpetually vexing to providers even though things eventually 'work out'. What are we talking about? Some HMOs are suspected of delaying the payout of providers' claims, through one mechanism or another - even though eventually the provider does collect what is owed to him.

Another method is BENCHING, described on the next slide.

Benching . . .

- **BENCHING is a DELAY in giving a decision to a provider about whether a patient can be admitted to a particular service – leaving providers and patients feeling 'left out in the cold' until an answer is given. This practice may occasionally occur when a request is made to admit to inpatient treatment or to other expensive services such as detox or partial hospitalization.**

Though not a rampant trend, States and other major contractors tend to watch such practices (including unnecessary delay in payment) closely. Providers may report such practices to the State, if to excess.

Yes, Care Management can be hard to live with.

The implications of 'CARE MANAGEMENT' (the HMO's term for deciding what services will be approved for a specific patient at this moment in time) and the PAPERWORK that goes along with it are 'major' for providers. And sometimes the impact is impossible for a provider to 'live with'.

We provide details about the clinical features of Care Management and how to deal with it, in the final lesson of this course.

HOW To Be Successful In This System?

Can you be SUCCESSFUL and ETHICAL at the same time? In courses 3D and 4D, we address the ETHICS of documenting when an insurance company is paying for treatment. They are our most popular courses.

To be successful in this system, you, as a PROVIDER, may need to rise to the occasion – learning NEW WAYS to DOCUMENT treatment and the NEED for treatment, and new ways to DELIVER treatment.

The decisions of the HMO – regarding authorization of your request to deliver treatment and then paying you for it – may well depend upon what you write in the client's chart. That is, how you document the need for the treatment and how you carried out the treatment. Doing what you have 'always done' may not work anymore. 'Coming out of the box' is the name of the game here. Creativity and flexibility are IN.

Retraining, Culling, New Hiring Practices . . .

In fact, retraining, culling, and some new hiring approaches are often necessary in agencies and group practices, in order to get the right staff who can rise to the 'managed care occasion'.

Some people will stay, some will go. Those who choose to stay will have to make significant shifts in how they THINK about and DO treatment, and also in how they DOCUMENT what they have done, in their clients' TREATMENT RECORDS.

Nevertheless, There Are Some New and Creative Ways to Participate in Managed Care – Out Of The Box, Ready or Not!

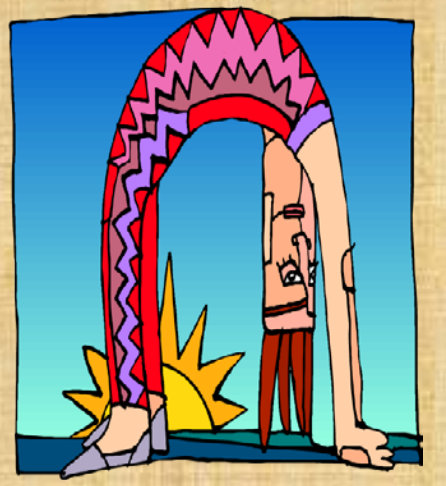
In Lesson 3 of this Course 3A, we give you some good examples of creative ways that providers can participate in delivery of managed care services. Some entail a bit of 'risk' for the provider but are mostly safe (minimal, manageable risk) and are eagerly sought by providers across the country. Your practice or program may already be engaged in one or more of these creative contracts, and if not, you may wish to consider it!

Shifting Where and How the Money Is Spent

- **In managed care programs, the HMO or other such 'at risk' entity CAN SHIFT where the funds are currently being spent – and 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 currently budgeted 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 that is GOOD for community providers!**

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, too, 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!**

Is Capitation Perhaps a Cash Cow for Providers? NO!

Sometimes PROVIDERS think that a lot of money might be made 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.**

SUMMARY: Capitation Can Work for Big Companies IF . . .

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

- **The State'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**

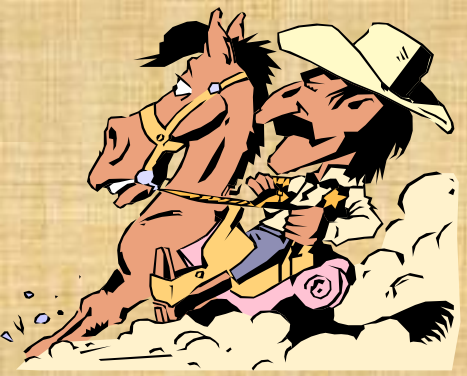
- **The FUNDS ALLOCATED to the program MUST BE adequate and must be carefully managed!**

With a Caveat . . .

At least, 'The Bad'

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.

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.



Maybe Even 'The Ugly'

What are we talking about? SUB-CAPITATION, discussed in Lesson 2 of this Course 3A, which looks at The Good, The Bad, and The Ugly of contract design.

Course 3A

Let's move on now, to Lesson 2 of Course 3A -
Understanding 'SUB-Capitation' Contracts and How That's Done – and How It Impacts Providers!

Return to My Home Page and click on Lesson 2 for Course 3A.