Lesson 3, Course 3B

CD Treatment In Transition!

Let's move on to a couple of examples of safe provider agreements with low 'risk' – which are 'in between' routine fee-for-service and other high risk arrangements.

Well, OK, what are we talking about here – WHAT special program and fee arrangements . . . which are 'in between' routine fee-for-service and those high-risk arrangements (like Sub-Capitation)?

Here, in this lesson, we will look at CASE RATES and SPECIALTY PROVIDER arrangements which may entail specialized contract options, with recommendations as to populations best served. These are fairly safe SHARED RISK or LIMITED RISK arrangements for CD providers. Who are we sharing the 'risk' with? The Health Plan, on a 'limited risk' basis!

There are a couple of ADDITIONAL specialized contracts discussed in Course 5B – such as Front End Assessment and Stabilization contracts – along with details about how to deal with claims payment issues and clinical contract negotiation issues, should you be interested.

How About Becoming a Preferred Or Specialty Provider – with Specialized Contracts?

***'Preferred provider' status*. Being a 'Preferred' or 'Specialty' Provider can allow a provider to take part in some creative contract scenarios – special program and fee arrangements which are 'in between' routine fee-for-service and the high-risk arrangements. Fees for SPECIALIZED SERVICE can be very attractive! You may need to take on more difficult clients and extra responsibility, in order to play a special role in the provider network . . . perhaps doing ALL of a particular type of service for the entire service area.**

. . . Preferred or Specialty Provider

. . . and the rewards can be worth the extra effort! Almost always, as a Preferred or Specialty Provider, you will receive more referrals and eventually more revenue, and will be in line for special contract opportunities with the Health Plan Contractor.

You may have to accept somewhat lower fees for the routine traditional outpatient services, but you will have the opportunity for ENHANCED compensation packages, for the NON-TRADITIONAL, SPECIALIZED SERVICES which you will be expected to deliver to the most difficult consumers.

Limited Provider Risk - Some Examples

A CASE RATE is an arrangement in which the State or managed care company pays the provider a contracted *flat rate fee* for each pre-approved enrollee, intended to cover (pay for) a specified 'package' of services which the client may require during a set period of time [such a month or six months]. In this contract option, the provider is given more control over the individual plan of care and the determination of which services will be provided to individual clients, and for how long. You do not have to ask the Health Plan for 'permission' at each step of the client's treatment process, with a case rate.

In a sense, the provider 'manages the care' of the client, rather than the Plan doing so. Case Rates are almost always limited to enrollees with a history of using expensive services – and the goal is to effectively and closely monitor the individual through less expensive, less restrictive, non-inpatient services.

. . . Case Rate

A key concept here is this: Very much like the Health Plan Contractor, with a CASE RATE, the provider is 'risking' or 'wagering' that his total pot of Case Rate dollars (the total amount that the Plan is willing to put into case rates with that provider) will *stretch* to cover the 'high end' (expensive) services that will probably be required by a *minority* of his 'case rate' clients . . . as well as the *less expensive* routine services required by the *majority* of his 'case rate' clients. And the provider is hoping that its careful management of the care which all of these clients receive will keep the number of expensive services to a minimum. In a sense, providers who take on CASE RATE arrangements are functioning like a 'mini-HMO'. They are 'managing the care' of their caseload.

The Difference between (Sub)Capitation and a Case Rate

You may have heard of SUB-CAPITATION. You may be wondering, "But isn't this just like (sub)capitation?" The answer is NO. Remember, in true capitation or sub-capitation, the risk-holder must treat ALL enrolled and eligible members who come to the door, no matter how sick they are. You CANNOT pick and choose your consumers like you can with a Case Rate. AND, unlike a Case Rate, with (Sub)Capitation the provider cannot simply say "I have all the clients I can serve." With a Case Rate you can take on as many 'case rate' clients as the program can handle (assuming that the Health Plan approves), and stop there.

And this is how you are limiting your risk . . .

Because the *number* of CASE RATE enrollees accepted for treatment by a provider may be limited by the provider, the provider is thus able to choose *how much risk* he takes, and can generally reject additional case-rate clients when he feels too stretched. HMOs and other such CAPITATED Health Plan Contractors cannot do that.

MAJOR CONTRACT POINT HERE: Make sure that your Provider Agreements (or the open, publicly established rules for the entire provider network) allow for 'capping' or limiting the number of CASE RATE individuals which you must accept into treatment.

. . . Case Rate

A 'CASE RATE' is a kind of risk that may be worth taking, if you know your population well and have a good array of services in place. Ask about a Case Rate for your MOST RECIDIVISTIC adult clients – AND for adolescents who have difficult to treat dual diagnoses (a mental health diagnosis, and perhaps involved with the juvenile justice courts, with co-existing major SA or CD issues).

This is indeed risk, but without 'hanging over the edge'.

. . . Case Rate

A question to ask: **Must you provide those extremely expensive inpatient and detox services if a case rate client needs it? (Hopefully NOT, unless your agency operates these services and has a special contract to provide them.) 'Which services you are responsible for' must be made very clear before a provider accepts such an arrangement.**

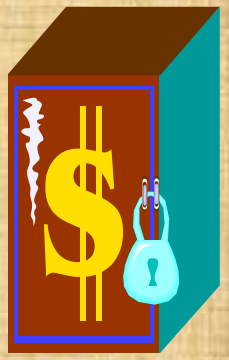
Then once we know what is covered in our 'case rate package', we can go about doing the things that we will need to do, to make it all work out in the end – just like our friends, the managed care companies! None of us wants to lose money!

- **Therefore . . . in this type of arrangement, it behooves the**

. . . Case Rate

provider to ensure that he has put into place ample DIVERSIONARY AND SUPPORT services for his clients, so that they will NOT REQUIRE the high-end expensive services [or will not relapse as easily following the delivery of such services]. This is a function of good Care Management – making sure that good service alternatives are available.

Caveat



Caveat to CD (and also MH) Case Rates:

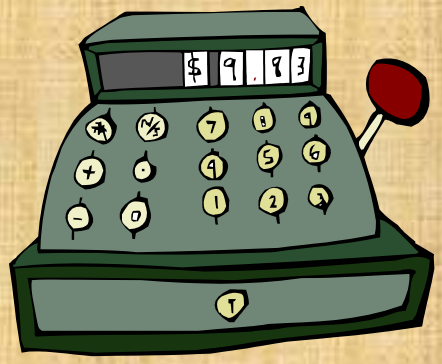
Unfortunately, the managed care company does not have an unlimited amount of money to plow into Case Rates for CD and MH consumers. Thus, in order to keep its own expenditures in line, the managed care company will almost certainly limit Case Rate arrangements to those clients who are the 'highest risk' clients based upon the client's recidivism history – and they will utilize fee-for-service contracts for the mainstream of the enrolled patient population. One possible exception to this may be Severely Emotionally Disturbed adolescents with a SA or CD diagnosis – who oftentimes are more cost-effectively served with a Case Rate due to the need for extensive in-home and community services.

Providers: Do 'Internal Utilization Management' of Your Case Rate Clients

- The need to do Internal Utilization Management (IUM).

Remember . . . Just as the managed care company must carefully MONITOR the progress of all enrollees through Care Management (or Utilization Management), the PROVIDER who is serving clients under a Case Rate fee will *also* need to closely MONITOR 'how-often-how-much' treatment is provided. Therefore you will need to develop an INTERNAL UTILIZATION MANAGEMENT (IUM) PROGRAM. You, as the provider, must ensure that the total amount of services provided to your 'case rate' clients does NOT cost more than the total amount of money that you are being paid. And you must do this while also ensuring that clients get what they really need. Quite a juggling act!

The HMO Benefits, Too!



The HMO or other at risk entity is simultaneously limiting its OWN risk under a CASE RATE, because the HMO pays a *flat fee for one or more full month(s) of services* INSTEAD OF paying a fee-for-service for each treatment visit that the client requires, delivered in the community, on a per-client basis. HMOs can save significant dollars with highly recidivistic CD clients – particularly if you are a CD treatment provider who runs a detox unit as well as outpatient services and includes detox in your Case Rate, for clients accepted into the Case Rate scenario.

More On Why Case Rates May Be Good for Providers and Certain Clients

If the Case Rate is a reasonable dollar amount per month [or for whatever period of time], such arrangements may also be more appropriate for some Chemical Dependency and Substance Abusing clients than a straight fee-for-service arrangement – particularly if the consumer is highly recidivistic.

Reason: The provider is given more control over the individual plan of care and the services provided to individual clients, under a Case Rate. In a sense, the provider *manages the care of the client*, rather than the HMO doing so – so the care is inherently more 'individualized'. Once the HMO has limited its risk through

. . . Case Rates for CD

granting a Case Rate for a client, it generally does NOT interfere with what the provider chooses to do with the client, so long as good care is delivered – AND so long as the client requires a bare minimum of inpatient treatment, which the Case Rate likely does not cover. (If the HMO is paying for inpatient or detox, they clearly don't want to see much use of those services. Otherwise, they will not feel that they are getting much benefit from the Case Rate. Makes sense.)

In summary . . . as with difficult MH consumers, this arrangement oftentimes results in optimum care for difficult CD clients, because the local provider is free to do whatever is needed for the client without additional 'utilization review' by the HMO. The provider can deliver the care at the very moment that the client needs the services, in the amounts that the provider feels is optimum, and

for the amount of time that the provider feels is optimum.

For example, if the provider feels that the CD consumer needs 5 days of detox, they can provide that, so long as detox is covered under the case rate. If the provider feels that the consumer needs 8 weeks of IOP, they can provide this, or if the consumer needs 3 admissions to residential rehab during the year, the provider can allow this without the permission of the HMO – so long as the services are covered under the case rate. Providers thus feel that they can be more attuned to the individual needs of the client in this way . . . managing the care themselves, under a Case Rate.

Credentialing Requirements

- **CREDENTIALING is required by managed care – and it can be truly threatening (even daunting) for providers . . . especially not-for-profit programs and CD Treatment programs which oftentimes have taken the paraprofessional path, instead of hiring heavily on the licensed clinician side. Credentialing is unavoidable, in one form or another.**

Your papers, please?

Issues for SA and CD Treatment Professionals . . .

- **BHOs require more licensed staff – programs and group practices should consider *contracted clinicians* (instead of full time employees) to fill in the gaps. Managed Care plans may also require a Medicaid Provider number, irksome to some Boards and individuals, and until recent years, very difficult for CD programs to obtain.**

Issues for Professionals . . .

- **Lobby (educate) the MCOs about flexibility in professional credentialing requirements. Press for approval of unlicensed Masters clinicians under licensed supervision, LCDCs, BA's and paraprofessionals to perform non-traditional MH and SA outpatient services such as 'wrap-around', CD education and counseling, intensive case management, and 'psychosocial rehab' services.**

Summary of Professional Issues and Some Final Notes

Access-to-Treatment Issues

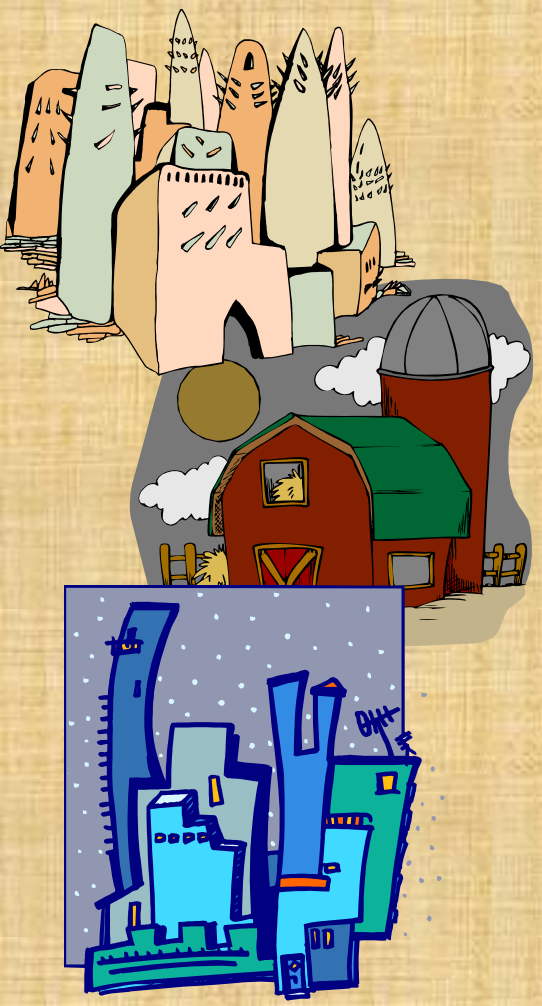
- **The goal of Managed Care is to ensure that the consumer receives**
  - **the right treatment**
  - **at the right intensity**
  - **for the right amount of time**

Whether or not this occurs consistently for CD clients is a matter of serious discussion in the CD treatment community.

- **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'. (More on that in slide 4.)**

- **Almost always, managed care does ensure rapid INITIAL services, convenience, no waiting lists. Even for SA and CD!**

Footnote: Cautions On Access



- **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, BHOs, and States must heavily involve stakeholders including advocates and consumers at the front end. They will regret it in the end if they don't, from the political fallout. CD providers must be proactive.**
- **Keep it simple. Consumers and providers should not have to jump through hoops to get in touch with the MCO, or the provider.**

Is there always better access? 'It depends!' Some believe that there may be significant access issues of another kind, related to Cost Containment and the Availability of Providers under the 'narrow networks' of the ACA.

The immediate goals of the Fed's and 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!

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'.

Non-Traditional Program Design Mandates – 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', ALTERNATIVES OR STEPDOWNS FROM inpatient and partial hospital or inpatient detox – such as several weeks of Intensive Outpatient (IOP).**

Non-Traditional Programs . . .

- **Emphasizes in-home services and other community-based interventions for persons with major mental illness coupled with CD, 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 'non-medical' observation for both MH and CD consumers, and transitional step-down units and programs.**

- **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 On Behavioral Health Services, For CD 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 some inherent shifts within the ACA. And we don't yet know how 'vertical integration' and 'narrow networks' will pan out for AOD.**

- **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!***

The 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.**

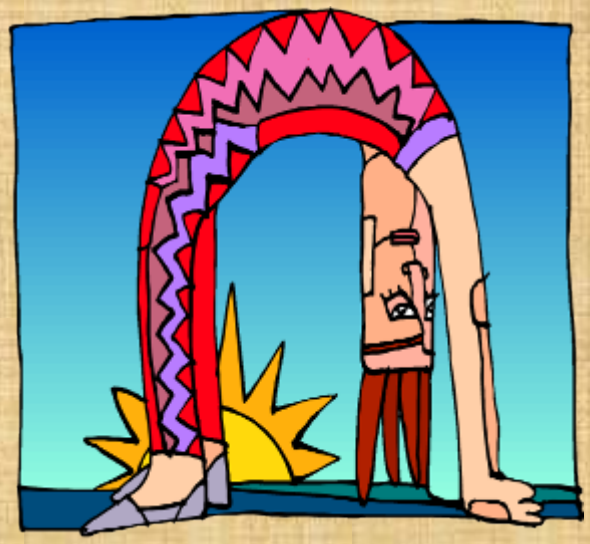
- **Managed Care Companies in 'The ACA Marketplace' expect for agencies to have ample access to professionally licensed staff (as opposed to unlicensed MA and BA levels). There is also a need for rigorous documentation of treatment services, with a strong 'clinical' orientation – which may be noxious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

The Effect On Services . . .

- **Despite our traditional treatment culture, we must be CREATIVE and FLEXIBLE, and willing to modify program designs. We must live with shorter lengths of stay (say goodbye to most automatic 28 day programs) , and we need to expand and 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 SA and CD (and even MH!) 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 and programmatic creativity is IN!*

Will no one save us?

- **Whining and fear will not stop this 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.

Managed Care – it's likely here to stay.

"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*

And here we are in 2015 – Not only has Medicaid 'gone Managed Care' throughout the country, but *so also have* commercial insurance companies and many Block Grant arrangements, and the ACA! It's here – most likely to stay.

Congratulations!

You have completed the final lesson in Course 3B, and the last lesson in this course!

You must pass all the quizzes for this course and must complete our short Feedback form, to receive your certificate, available online within your account.

To reach the links for the quizzes and the feedback form, just close this page now, and you will return to My Home Page – or you may return to the site when its more convenient for you, and just log in to your My Home Page – at any time, 24/7.

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