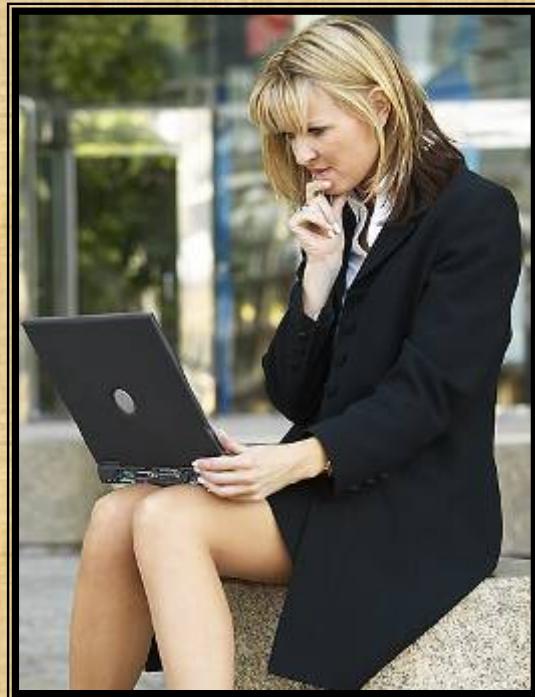
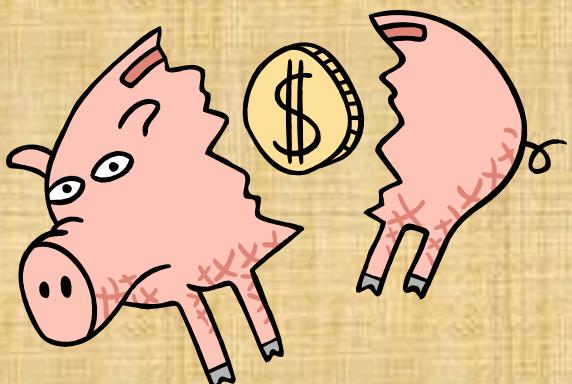


Course 1C



Lesson 2 of Course 1C

**More On Understanding How Managed Care
Works . . . And An Introduction to Clinical and
Program Impact (and Opportunities) for
Providers**

In order to understand what drives the Managed Care Company's CARE MANAGEMENT process, we have to understand 'where they are coming from' in terms of the CONTRACTS they have with the State or other health care entity. We talked about 'Capitation' contracts in previous slides, as one type of 'risk based' contract. But there are VARIATIONS of this type of contract. And it's helpful to know a bit about these, because they certainly do affect the provider and the clients whom we serve – some in good ways, some not so good.

And, sometimes, the provider is expected or offered the chance to 'share the risk' with the MCO . . . to participate in the CARE MANAGEMENT process, . . . i.e., limiting 'WHO' gets 'WHAT' type of care . . . and for 'HOW LONG'.



Remember What Capitation Looks Like?



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 other managed care company. 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? And then we saw how they do it – through many different maneuvers which CONTROL COSTS. And there are multiple problems which can occur.



But first . . . are there **OPTIONS** in how managed care plans are designed by states, which can avoid some of the potential problems?

YES, there ARE options in how a State designs its behavioral health managed healthcare plans.



Many state-sponsored Managed Care plans 'go all the way' with full-blown 'total risk' CAPITATION contracts for Medicaid *from the outset*, BEFORE doing any managed care pilots. And some may go even FURTHER: They may do an 'all inclusive' or 'all-funds' capitation arrangement for Behavioral Health . They don't limit the conversion of the funds to Medicaid or to one Block Grant or another! Want an EXAMPLE?

Options . . .

An example of an 'all-inclusive' or 'all-funds' managed care plan for Behavioral Health is a **BLENDED FUNDING Capitation arrangement**. This is where an MCO takes on and manages **ALL** of the Medicaid behavioral health funds **AND** all or most other behavioral health funds within a geographical area . . . for **ALL** disability groups including Mental Health (MH), Chemical Dependency (CD) and Substance Abuse (SA) . . . and for **ALL** ages (adult and child) . . . taking even the Community MHMR Center and SA/CD treatment funding. It's the type of plan that can be The Ugly – but eventually it could become The Good. Sort of an 'Ugly Duckling Into A Swan' story. More about this in a moment.



OTHER Options . . .

8— State governments CAN choose to move slower than these FAST TRACK approaches. They may want to consider a scaled-down or 'phased in' managed care model – keeping some of the 'old' features of the delivery system, at least for a while, to give the system a chance to adjust, moving the new approaches in slowly.



8— Providers and advocates may want to press for 'phasing in' managed care, in states where managed care is not yet in full swing. And they may want to press for 'simplicity' in the design of the plan.

8— **NOTE:** The degree of complexity and the scope of the managed care plan design typically correlate highly with the number of problems. That is, the more complex and 'big' the plan, the more problems!

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

Remember that CAPITATION is the main way that States control cost of programs like Medicaid and Medicare. CAPITATION CONTRACTS CAN WORK, if done correctly.



'The Bad'

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! Read on . . .



'The Ugly'

Sub-capitation – What Is That?

This is a type of Behavioral Health contract arrangement in which the States or the Feds *initially* contract healthcare funds to one or more MCOs – and the MCO is carrying all of the RISK. (Remember what CAPITATION and RISK are, from the previous lesson.)

But THEN the MCO decides (with State approval) to *carve 'out'* (or pass on down to another entity) most of the behavioral health contract funds. Why? Because they want to OFF-LOAD THE RISK OF FINANCIAL LOSS onto another organization. This is the ultimate form of an MCO 'controlling its costs'.





Behavioral Health Sub-Capitation.

So the contract funds are passed down, *along with the risk*, to this second managed care company or other organization – which may even be a large **PROVIDER ORGANIZATION**. That company or organization then acts as the MCO which ‘manages the care’ of the enrollees.

This second company COULD BE another large managed care company like an HMO or BHO (Behavioral Health Organization). BUT it COULD BE a Hospital District, or a large Community Mental Health or Substance Abuse Provider Consortium, or some other professional or governmental group. They would now hold the capitation money (what’s left of it) and also the RISK that they will LOSE MONEY in the process of ensuring that all of the enrollees get MEDICALLY NECESSARY SERVICES. 9

Sub-capitation . . .

Here's the problem with this maneuver: The original MCO has not only 'OFF-LOADED' its risk to the new 'carve-out' organization – *it has ALSO peeled off a percentage of the contract money for its own 'administrative costs'*, before the pot of money is given to the new organization. *So what is wrong with this?*



***Usually
'The Bad'***



Sometimes The Ugly!



Sub-capitation . . .

- The problem is this: It's called "Administrative Rake-Off." A total of 10-15% of the original funds may be retained for 'administrative' purposes by the original MCO [a.k.a. 'administrative rake-off'] – and then ANOTHER 10-15% will be set aside ('raked off') for administrative costs by the NEW 'carve out' company. Thus, there is considerably LESS MONEY AVAILABLE for direct care of patients after all is said and done. Look at the next slide to get a good idea of how the amount of money for patients starts to really shrink!
- If this option is allowed, the State should at least *prohibit additional* sub-caps or 'off-loading' of risk even further down the line (which would be a 'Serial Sub-Capitation').



Behavioral Health Sub-Capitation – Where's the Money Go?

This is how the MONEY flows in this model.

From the State or Feds



**To the primary contractor(s) – one or more MCOs, who hold
all of the money and all the risk**



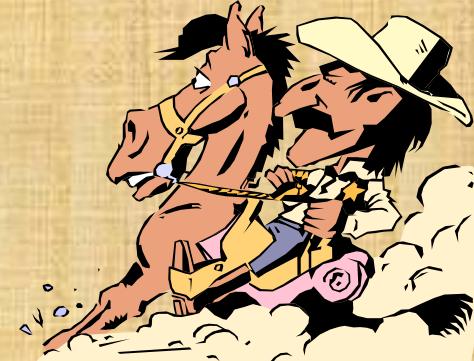
**To the SUB-capitated MCO or other organization, who takes
approximately 90% of the original money and all of the
risk**



To the Final Providers of Services.

**Note that there is an 'ADMINISTRATIVE RAKE-OFF' of approximately 10% before
the funds are passed to the Sub-Capitated entity. And then the sub-capped
entity has its own administrative costs to pay, out of the 90% that it receives.
Leaves maybe 80% of the original funds for client care.**

Can it get worse? YES! It's *Serial Sub-Capitation* – and it's definitely 'The Ugly'



- **Serial Sub-Capitation [Some simply refer to this as a Sub-Sub-Cap]** – This is a contract model in which the **NEW sub-capitated organization** (as in the previous slide) OFF-LOADS (OR TRANSFERS) its assumed risk AGAIN, by passing the money and the risk down to a **THIRD party**. This might be a CMHC, a large group practice, a physician group, or not-for-profit association. **This is SERIAL SUB-CAPITATION.**
- **This *newly* sub-capitated group or organization then either provides the services themselves OR contracts with and pays other providers below them – perhaps does both of these things.**

Serial Sub-Caps . . .



What's the problem here? Both the *original* MCO and the *original sub-capitated* organization hold out a chunk of the funds for 'administrative costs' . . . and the third organization (the second sub-capitated group) will ALSO hold out some of the funds for administration. *So not much is left for the providers OR the patients!* Want to see a graphic flow chart of how the money travels? Read on . . .



Behavioral Health Serial Sub-Capitation – Where's the Money Go?

This is how the money flows in this model.

From the State



**To the primary contractor(s) – one or more MCOs, who hold
all of the money and all the risk**



**To the SUB-capitated MCO, who takes approximately 90% of
the money and all of the risk**

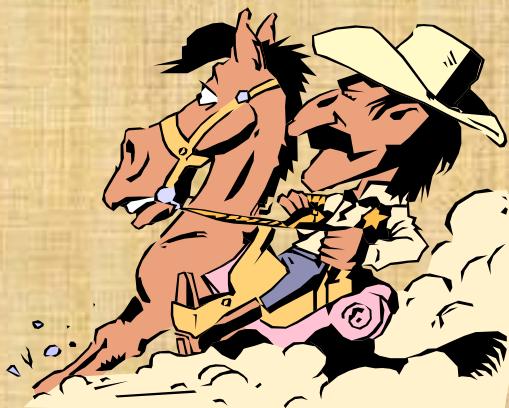


**To ANOTHER 'SUB-capped' entity - perhaps a Community
MHMR Center Consortium – who takes approximately
90% of the remaining money and all of the risk**



To the Final Providers of Services . . . way down the line!

Summary of Serial Sub-Capitation



The fact that capitation is such a **HIGH RISK** arrangement is precisely why some MCOs and BHOs may try to **OFF-LOAD** the risk to a third group down the line, through **SUB-CAPITATION** of their original contract.

The Ugly

Unfortunately, some MCOs feel that PROVIDER GROUPS are as good as any to take on this transferred risk. When that happens, we believe that this is “The Ugly” of “The Good, The Bad, and The Ugly” in contract design.

Important Note For Providers About (Sub)Capitation Agreements: We DO NOT Recommend Them for Provider Organizations, No Matter How Confident You Are That You Could Handle It.



Capitation or Sub-Capitation may be tempting for a 'large' provider organization to take on – especially if it wants to maintain 'control' over the shift to managed care. However, no matter how well managed, the risks are still great with ANY true capitation or sub-capitation contract. Providers must be extremely wary of taking on such high risk 'capitation' or 'sub-capitation' contracts, even if they are tempted to do it.

Provider Notes . . .



In general, *CEU By Net!* believes that this type of full-risk capitation contract (Capitation or Sub-Capitation**) is generally NOT WORKABLE FOR TREATMENT PROVIDERS to take on (as the risk holder), no matter how 'big' the provider is; we believe that true capitation contracts are 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.**



Could this really happen? Would any provider group actually take on this type of serially capitated contract?

Yes, we think that it easily could happen . . . especially in the new Affordable Care Act (ACA) environment. In the ACA, in a proposed design called *Vertical Integration*, all of the funds to treat **BOTH** the medical problems of the client AND the behavioral health problems would be given by the primary MCO to **ONE ENTITY** to manage – and the receiving entity is called a "*Medical Home*". The idea is to **INTEGRATE** physical and behavioral medical care.

In a Medical Home arrangement, a family physician or similar small physician group would be responsible for directing **ALL** of the care that the individual needs, which means that he or she or 'it' would need to make arrangements to pass the patient down to appropriate caretakers who specialize in what the patient needs.

Because the Medical Home has a budget – and has likely already been sub-capitated – he or she or it would need to be very judicious in how much is passed down. Therefore, the 'end provider' is going to receive a **VERY TIGHT** budget to treat the clients they receive.

OK. Switch Gears Here. Let's talk about Blended Funding Carve-Outs.

Blended Funding Behavioral Health Carve-Outs – CAN be one of the 'The Ugly' managed care contract designs, *at least initially*. But after a 'break-in period' and with careful management and State oversight, it can move into 'The Good' category.

This is a funding arrangement in which behavioral health funding from *multiple* community and governmental funding sources is consolidated into a single large pot of funds, and is given to a behavioral health managed care company or large service provider to manage. The blend may include Block Grant funds (CD, MH), General State Revenue dollars, Medicaid, and various local match funds.



**The Ugly?
Sometimes!**



**The Good?
Perhaps
Eventually!**

In some counties or communities, this has worked very well, year after year. Coordination is good, and ideally there are no waiting lists. However, some counties eventually become weary of the Big Company who controls all of their county funds – and they rebel. They want their county money back. ALL of it. They have learned a lot during this initial period – and they are ready to ‘do it’.



- Yes, this type of Blended Funding Carve-Out can be dangerous, especially when not prefaced by a true incremental pilot. There are multiple ways to do pilot phase-ins such as this, including ‘shadow billing’ pilots where providers do a practice run on estimating the revenue they will (and will not!) collect under managed care.
- Because it takes ALL or most of the money in the service area and pools it into one big pot, it may initially dismantle or stress the ‘traditional provider’ delivery system, may temporarily damage or disfigure the ‘safety net’. Or the ‘safety net’ may seem to fit nicely into the community at first – but after a while, the safety net seems to wear thin; community activists decide that they can do better than this.

- **Downside: May create havoc for a period of time, may take some traditional providers out of the game, and may leave some consumers who were formerly covered by one of the 'annexed' funding streams without services.**

- **Downside: Places traditional providers at grave risk – IF they are not diversified in their funding base (i.e., if they rely exclusively upon block grant or State General Revenue annual contracts). They must 'come out of the box or die'! Must diversify their funding streams to survive.**





YES, there is an up-side!

CEU By Net believes that the key to keeping the up-side 'up' is to never forget that the money for this blended project belongs to the COMMUNITY. The MCO must keep its fingers on the PULSE of the community. Don't become lax. Ensure that the needs of the community are your FIRST priority - always.

**Blended Funding Carve-Outs.
They DO have an upside!**

Upside: IN THE END, Blended Funding BH Carve-Outs can produce a viable and newly configured delivery system, with expanded CHOICE of providers for consumers, greater FLEXIBILITY for providers to offer innovative services, enhanced CREATIVITY brought about by competition among providers, and more cohesive SYSTEMS of care, across multiple agencies.

Blended Funding Carve-Outs . . .

- **Additional Benefit: Consumers who move 'on' and 'off' of Medicaid eligibility may not lose their services when 'off', under this plan. They may be able to continue services (likely with the same provider) because there are other non-Medicaid funding mechanisms blended in, which can cover their care. In this case, the consumer likely 'never knows the difference'. It is all one big pot of funds, now.**



Blended Funding Carve-Outs with CD / SA

- **Caveat:** Many feel that the positive effects of Blended Funding BH Carve-Outs are primarily applicable to Mental Health providers and services and consumers – and are NOT necessarily as beneficial to Chemical Dependency providers and consumers. Although there is room for innovative services and enhanced creativity for CD/SA providers, many feel that the nature of chemical dependency treatment is somewhat at odds with the limitations that MCOs provide on treatment.



Blended Funding Carve-Outs with CD / SA . . .

Caveat, cont. . . . In Blended Funding Carve-Outs and other managed care contract models, the standardized protocols which are often used by the managed care companies are believed by many to result in **QUESTIONABLE CLINICAL OUTCOMES** for chemically dependent and substance abusing consumers. Reason: The somewhat standardized CD/SA protocols used by the MCOs to control costs may NOT adequately accommodate the CD population's inherent potential for repeated relapse on the road to recovery.



Blended Funding Summary

- States, Providers, and Advocates should avoid the 'Pie In The Sky' scenario! The key to success in a Blended Funding Carve-Out plan is this: Incremental, step-wise pilots to carefully prepare the entire system for the shift in 'who' manages the healthcare \$\$\$ (now, it is the managed care company) . . . and 'how' the \$\$\$ are earned by healthcare providers.
- As providers, we must also pay attention to the need to diversify our income (seek out multiple sources for revenue – don't just rely on this one contract). This is a major check point to success in a Blended Funding Carve-Out! It can be done. But as they say in the South, 'mind your chickens'.
- To the MCO: Never forget that the money for this project belongs to the COMMUNITY. Keep your finger on their pulse. Listen to what they are telling you. You are a guest here.



Who can benefit from understanding all Managed Care Issues?



- Governmental (State, local) planners and administrators – who need to consider all of the angles, the upside and the downside, the ins and the outs, before forging a plan.
- Program administrators and managers, provider networks and individual practitioners – who must be *proactive* in advocating for workable solutions to managed care implementation . . . workable PROGRAMS which will meet the needs of consumers in enhanced ways. This shift is an OPPORTUNITY to improve the delivery system!
- Mental Health and CD/AOD Advocates and Consumers – this is *your* system they are preparing to change. Be proactive!

And remember . . . MCOs are looking for new providers, if needed, as part of Cost Containment and the effort to diversify Treatment Options. This will surely shake things up. And it may be for the better!



The MCOs are moving away from the historical idea that traditional providers 'can provide whatever they are comfortable with, and it will meet all the needs.' Instead – in order to CONTROL COSTS (i.e., 'cost containment') – the managed care MCOs want to see a FULL ARRAY of services out there in the delivery system . . .

. . . even if they have to force the issue through bringing in NEW providers from out of state or from elsewhere in the system to deliver the services that are needed.

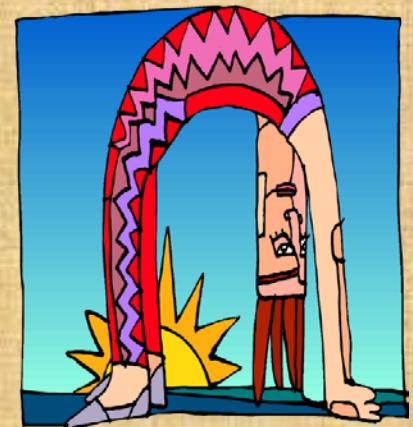


Remember that - because of the populations that the MCOs must now serve in public sector managed care plans such as Expanded Medicaid and ACA (ObamaCare) - they will have to offer **SPECIALIZED** services to meet the needs of severely impaired individuals. These specialized services will hopefully reduce the need for more expensive services.

Remember that when an MCO REDESIGNS THE DELIVERY SYSTEM, they must ensure that there are services which will DIVERT patients from UNNECESSARY admission to the more costly levels of inpatient care – i.e., 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 one way that the managed care company can CONTROL its COSTS (i.e., its expenses).

Clearly, 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 MCO 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 MCO's coverage.

Providers are encouraged to be flexible in providing and using alternative STEP-DOWN programs for their clients.





Alternatives to traditional treatment

Even if the provider is opposed to the MCO'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.

As most of us know, over the past few years, programs have been re-designed with good results. Now these trends must become a part of the Health Care Reform Movement. 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.

And remember that alternative services may be even better for the client!

Managed care companies and flexible behavioral health providers emphasize INNOVATIVE SERVICES (a.k.a. 'non-traditional' or 'alternative' treatments) which are 'outside the box' – i.e., which depart from the traditional way that services have always been provided. And we have found that many of these treatments work BETTER and perhaps FASTER than the traditional approaches.



Example: In-School Services and Intensive Home-and Community-Based Services for Dual Diagnosis Adolescents.

Flexibility In Programming – It Can Be Painful to Some.

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 . . . having to play 'Mother May I?' with the MCO. These are major issues to the uninitiated.



Providers, States, and the MCOs must alter how they usually operate and think.



- **For anyone involved in healthcare:** Productivity, outcomes, and cost effectiveness are the new watchwords – ‘doing good’ is no longer enough.
- **For all providers:** We must not ignore the potential impact of the shift to managed healthcare. ‘Resting on our traditional laurels’ – in terms of how we deliver services and how we obtain our funding – places agencies and private practices in an extremely vulnerable situation.

Providers must move 'out of the box' to survive – and the MCOs must move out, too!

Because of the new designs emerging within the ACA, it is a competitive and creative provider market. If they want to participate, traditional providers and private practitioners must 'move out of the box'. This is true even for MCOs, who must adjust THEIR business, too.

- For example: Many MCOs have been serving traditional commercial insurance enrollees only. But to participate in the expanded ACA vision, they must NOW serve the indigent and more persons with MAJOR BEHAVIORAL HEALTH DISORDERS (including persons with severe mental health and chemical dependency issues that may not have been eligible before).



New opportunities are abounding!

If such DIVERSIONARY and STEP-DOWN services are not already available among current providers within the community, the MCO will likely approach the current providers to START delivering these services.

And IF they are not willing to provide specialized services, the MCO will SEARCH for NEW players (from inside or outside the delivery system) to provide the services. This has major implications for providers who want to participate in a managed care plan.



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