

Course 3B continued . . .

Part B of Lesson 1 – Introduction To the Impact of Managed Care Upon Our Finances and How We Do Treatment . . . And Intro to Outcomes Measurement



Key Features of The New Direction In CD Health Care

- **New financial arrangements – more fee-for-service and case rate arrangements, rather than flat rate annual contracts and state grants – yes, it has really happened!**
- **The need to develop some new funding streams – may be essential for providers, in order to survive**
- **New diversification of what we do, programmatically and for whom**
- **More service coordination among providers, less isolation . . . provider managed networks and consortiums can survive, together.**
- **Emphasis upon treatment *outcomes* and internal Quality Management systems – ‘doing good’ is no longer enough!**
- **Competitive market – it’s out of the box or die!**
- **New public-private partnerships are expanding**

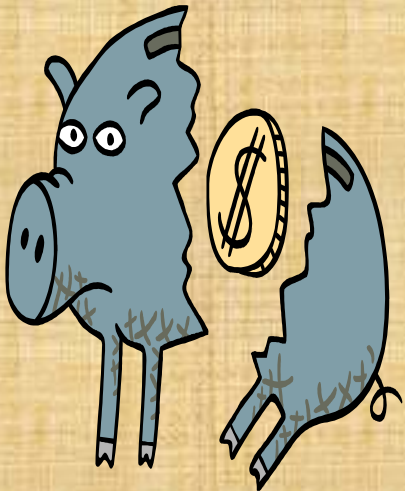
Before we go on, some notes about the typical insurance company's contract with the State to provide treatment for a Health Plan's enrollees. And some clarification of the RISK that a managed care company has taken on, because the RISK impacts the decisions that they make about our clients.

In a CAPITATION contract, the State pays the HMO or other insurance company (aka, "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 Contractor to keep its doors open and to pay for patient care. Even so, \$6 or \$11 per-member-per-month doesn't sound like much money to take care of an individual, does it?



Capitation . . .

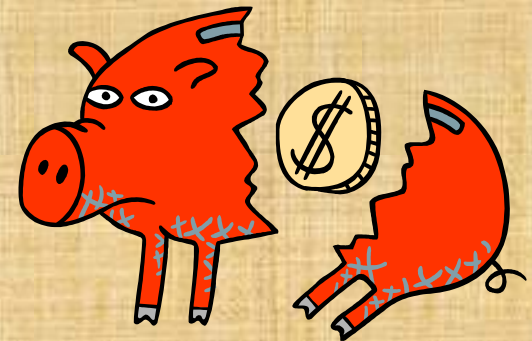
And . . . the 'AT-RISK' (capitated) entity (e.g., the HMO or other Contractor) must provide 'ADEQUATE, MEDICALLY NECESSARY TREATMENT' for ALL ENROLLED, ELIGIBLE consumers who present for services – no matter how many consumers appear for services, no matter how many times they present for care.



THIS IS A HIGH RISK RESPONSIBILITY! Will there be enough money, so that the contractor 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 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 Contractor runs out of money. Yes, even when the Contractor is a BIG powerful HMO.

The real danger here, for HMOs and other such health plan Contractors: If the total COST of care provided to the enrolled population is more than the contract PAYS, then the Contractor will probably fail (lose money). 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.'



CARE MANAGEMENT!



The 'at risk' entity ("Contractor") **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'.

HMO/Contractor Risk



How's it work? The HMO or other such Managed Care Contractor 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 which can be somewhat subjective.



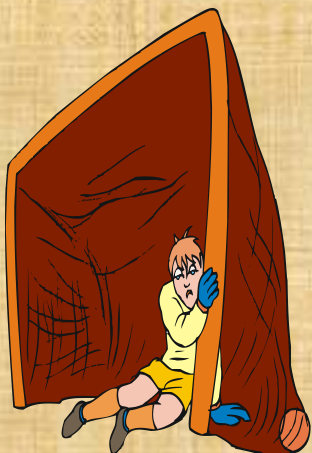
Managed Care Contractors make their 'Care Management' decisions (a.k.a. 'Utilization Review') based upon whether or not they believe that treatment is 'MEDICALLY NECESSARY' for stabilization and improvement, and whether the treatment is believed to be ESSENTIAL for persons with the patient's specific DIAGNOSIS. Also, is the treatment having a POSITIVE IMPACT up on his condition?

For the CD client, Care Managers 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 from a 'medical' perspective.*

Clearly, the managed care company's decisions may contradict a provider's own PROFESSIONAL BELIEFS about 'how much' of 'what' is needed at any given point in time.



For example, the managed care company will almost certainly *limit* how long an individual remains at the more expensive levels of care. In the past, providers were able to keep a person in a protected, intensive level of care for many days or even weeks – or months. That's very unlikely to be approved in this day and age.



Bottom line, however, is this: Painful though this transition is for providers and also for clients, COST CONTAINMENT is necessary for a state and a country that is struggling to control and manage its health care costs.

The TRANSITION to managed care is NOT easy for providers – OR for the Health Plan Contractors who take on the risk.

If you desire more information about the clinical and programmatic details to be aware of when contracting with a Health Plan – and how to deal with them when there are problems in claims payment because of clinical errors you may have made – you may want to check out Course 5B *'Where The Rubber Meets The Road'*.

A Couple of Health Plan Cost Control Strategies

📁 One way that the Health Plan Contractor and the State can control the cost of care is to reduce the number of people the Plan must treat. How? The criteria that make an ENROLLED person actually 'ELIGIBLE' for certain costly services can be made more restrictive . . . particularly if money for behavioral health is tight – 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 alcoholic' have begun to disappear from the Managed Care treatment scene, as money grows tighter. 12



Regardless of our feelings about this approach, it is clear that the 'AT RISK' HEALTH PLAN CONTRACTOR (HMO OR OTHER) 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'? Simply this: As we indicated in earlier slides, under managed care, the Care Manager 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.



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, Health Plan Contractors do need to carefully ‘managed the care’. 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. Again . . . that’s why they call it ‘Managed Care.’

There Are New Ways of Doing Things – Out Of The Box, Ready or Not!

To be successful in this system, providers may need to rise to the occasion – learning NEW WAYS to DOCUMENT treatment, and new ways to DELIVER treatment.



FOR EXAMPLE, the managed care company will probably LIMIT how long an individual remains at the expensive levels of care (like detox). How do they limit this? The HMO may 'step them down' to a lower level of care (i.e., less intensive and less expensive) before the provider (in the past) would have done so. Is this really 'bad'? Not necessarily, depending upon the medical condition of the client at the point of discharge, and whether there are good alternative services (such as CD-IOP). More on that later.

HealthCare-Driven Impact Upon How We Do Treatment



- The *new approach* to Health Care brings treatment decisions out of the box, and out of the closet . . . and has no 'sacred cows'!
- It works to ensure that the consumer receives the 'right product', rather than what is simply 'traditional':
 - ↪ the right treatment, in the right place
 - ↪ at the right level of intensity (Level of Care)
 - ↪ for the right amount of time
- It actively 'manages' providers and contracts, i.e., continuously assesses if providers are providing what the purchaser is wanting and needing, just like Amazon and Google and Apple work with their sub-contractors.

Overall Impact Upon Providers

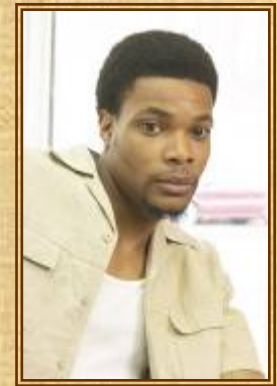
- **Reliance on state authority and funds will diminish – less ‘block grant funding’ will be available as the Feds encourage fee-for-service and similar arrangements.**
 - ↳ **Providers must develop multiple funding sources with different ‘products’ and requirements – essential!**

- **Providers need to attend closely to the impact of new legislation – re public sector funding methods (like for Medicaid, Medicare, and block grants) – and at how the Managed Care Plans handle substance abuse treatment.**
 - ↳ **There is almost certainly a need for traditional CD treatment to *change up its programming*, and to re-examine its organizational practices and traditions.**

A CD Issue Related to Care Management Decisions



Special Note: Standardized Level of Care protocols (such as those typically used by the HMOs and other insurance companies) are believed by many to result in questionable clinical outcomes for chemically dependent consumers. Reason: These protocols may not adequately accommodate the CD population's inherent tendency to relapse repeatedly while they are on the road to recovery. What to do here? Encourage your state and Health Plan Contractor to engage in good Quality Management studies of outcomes for CD patients! And for your most relapse-prone clients – especially those who recycle in and out of detox frequently – ask for a 'Case Rate', where you can make treatment decisions more freely – where you 'hold the cards'.



Yes, there's a new slant to programming, which challenges our SA/CD traditions. Some of the features . . .

- **Centralized access to care may be a part of the Health Care Plan – and the need for PRE-AUTHORIZATION by Care Managers is almost a ‘given’.**

↳ **This challenges our ability to make independent treatment decisions.**

↳ **It challenges use of the ER as the after-hours contingency, and rejects 28 day treatment modalities as the tried-and-true.**

- **It places MAJOR emphasis upon LEAST-RESTRICTIVE recovery programs. It avoids ‘unnecessary’ hospital admissions, ERs, and detox units for more than a very few days, and discourages ‘residences’. Moves beyond ‘cocoon’ treatment of the consumer – into the new ‘mainstream’ we go.**

Does this mean what it sounds like? Is Managed Care re-designing the CD delivery system? Well . . . Yes, it is.



This movement challenges our treatment traditions . . .

- **It adds more CRISIS AND ‘STEP-DOWN’ SERVICES**
– including ‘wrap around’ services for CD adolescents – in states with good CD funding, or perhaps in coordination with the Mental Health side. ‘Non-traditional’ options are front and center.

↪ **But it challenges our comfort level and our desire to continue what we think we ‘do best’.**

- **It coordinates MOVEMENT of the consumer FROM PROVIDER TO PROVIDER, according to the Health Plan’s perception of the consumer’s needs – which can ensure more and better options for our clients.**

↪ **But it challenges our desire for independence as a self-contained business and causes fear of competition.**

**But it’s
NOT all
‘bad’ for
our
clients!**



. . . challenges our treatment traditions.

- **There's LESS categorization of clients and their needs (no more 'everyone goes to 28-day first, after detox') . . . and MORE flexibility in treatment options and in program design – which is already 'unbundling' the ASAM criteria.**



This trend may significantly alter ideas of 'WHO and WHAT' is appropriate to receive various treatment options, AND it leads us to expand our repertoire . . . just like big business!

- **An external spotlight is on our outcomes – which can be scary, especially in the CD field which is recidivistic by nature.**



This can be a shock to our system, but . . . it's just like the shift that any Big Business undergoes!

Outcomes Measurement

Remember what we said about the new Affordable Care Act (ACA)? We said it was driven by OUTCOMES.



The Emphasis Upon Outcomes and Outcomes Measurement – Their Role in How CD and Managed Care Work Together

Under the new health care reform, we no longer have 'forever' for treatment to work.

Managed Care is a 'short-term intervention' mindset.



This is obviously problematic for the CD and Substance Abuse Treatment field, because the nature of our clients' illness is recidivistic. And obviously managed care companies do know this. And in fact they are responsible for ultimately keeping all enrollees under their care safe and stabilized. Therefore, what they seek to do, essentially, is this:

It's Nationally Driven

A focus upon OUTCOMES began over 20 years ago, with SAMHSA's first administrator – Nelba Chavez. And now it has come full circle with the Affordable Care Act.



Payors and funders are no longer willing to continue support of MH and SA/CD services based upon faith or tradition. SAMHSA was ahead of its time. This quote was from July 1994:

"State substance abuse agencies can make a strong case for federal and state funding of their programs simply by showing that they are effective . . . This is not the time to say that we don't know anything."

**Nelba Chavez, Ph.D.
First Administrator of
SAMHSA**

Yes, There's A New Emphasis Upon Outcomes, and It Looks A Lot Like Apple. Google. Yahoo. Amazon.

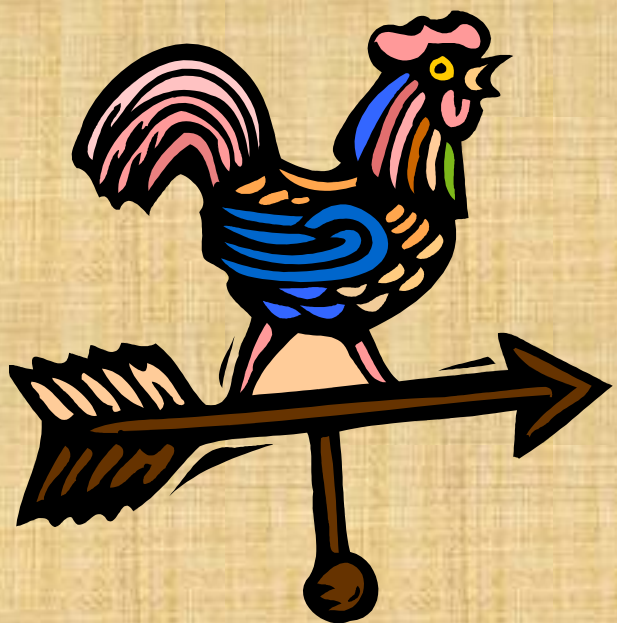
- **We need outcomes data elements just like big business . . . which ask:**
 - **Did it work? If so, how well?**
 - **Did our customers like it?**
 - **Was it what they needed and wanted to buy?**
 - **Will they want to buy more when its needed?**



Just like Big Business, we must use outcomes to . . .

- **Change programs/approaches that don't work (i.e., those with poor outcomes)**
- **Promote those that do work (i.e., those with good outcomes)**
- **Alert us if program cuts or modifications are hurting rather than helping**
- **Document cost savings and success, which shields CD services from budget cuts in State and local and HMO budgets.**

Outcomes are our weather vane



- They keep us on track, signaling the need for a shift (at the client level, at program level)
- They tell us when we are “doing the right thing”
- They put things in perspective, for us and the clients

Examples of outcome studies from states

California: The \$200 million it required to treat 150,000 substance abuse clients resulted in \$1.5 billion in savings from crime reduction and hospitalization.

Texas: Inmates who completed an intensive SA/CD therapeutic community program while in prison had only a 7% recidivism rate. Those who did not complete or participate in the program had a 19% recidivism rate.



Other studies . . .

- **Iowa and elsewhere: Women do better in 'women only' CD recovery programs. And, further, women do better in residential recovery programs when they can keep their children with them in the residential facility. Here please read this as "short term residential facility" - obviously.**



Problems With SA/CD Outcomes



- **There's a high drop out rate (e.g., up to 40%) after one or two sessions.**
- **Comparing program completers with non-completers in terms of outcome is difficult: the latter don't respond to follow-up inquiries.**
- **The instance of a co-existing major mental disorder with AOD users [a high prevalence] complicates meaningful outcome measurement and comparison.**

Examples of What to Measure



- **Criminal recidivism following different types of post-release CD programs, in men vs. women**
- **Further penetration of the juvenile justice system following Intensive Home Based ('Wrap Around') Treatment for adolescents vs. regular outpatient programs**
- **Re-admission to inpatient or detox following IOP vs. regular outpatient**
- **Reports of abstinence from self vs. family vs. others**

What else to measure . . .

- **Holding a job – for clients who have participated in different types of treatment programs, at 6 months post-discharge.**
- **Length of gestation in pregnant women with CD histories**
 - **Weight of newborns born to SA/CD moms**
- **Outcome of toxicology screens – random vs. scheduled**
 - **Academic achievement of adolescents who have participated in different types of programs, at 6 months post-discharge.**

What to Compare

- **Progress of cocaine abusing moms who have their kids 'live in' with them during residential rehab, with those who don't.**
- **Attendance rate for drug abusers who are rewarded with food or prizes for daily IOP completion, compared to those who are not so rewarded (or compare with self for the month prior to rewards)**
- **Comparison of sobriety and productivity at 6, 9, and 12 month follow-up post-discharge, following inpatient, residential, half-way house, IOP, regular outpatient, and combinations of these modalities. [And yes, we know that it is hard to keep track of this population, but we must give it our best effort.]**

What else to compare. . .

- Compare effect of short lengths of stay in residential or half-way, with longer stays
- The success of those who have the benefit of 'step-down' programs such as Intensive Outpatient (IOP) with those who don't
- Following inpatient detox, compare IOP participants who also have AA/NA – with those who go straight to regular outpatient and AA/NA



Good outcomes data make program decisions easier – and serve as a basis for funding.

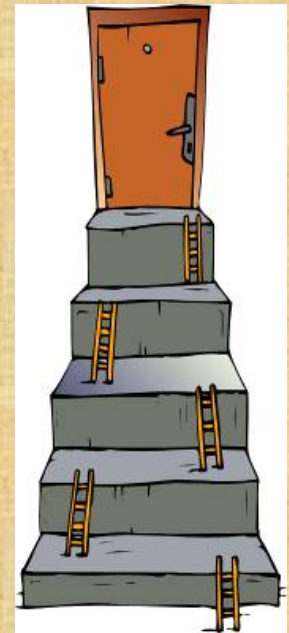
A Cautionary Note About Outcome Measurements . . .

When They Become 'Performance Criteria' in Your
Contract With a Managed Care Health Plan Contractor.

In a couple of words . . .

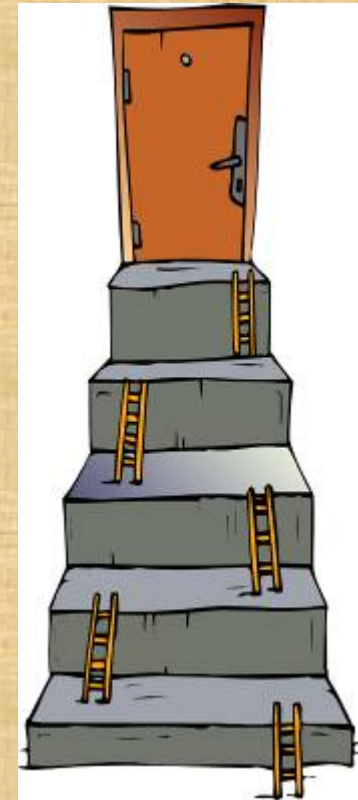
Be careful!

Read on . . .



Performance Criteria: Those 'Outcome Measures' That Are Contractual

- **Performance Criteria for Chemical Dependency, when placed in Health Plan contract, can be a problem. Do the performance criteria which are specified in the contract look unreasonable to you? Or do they frighten you? If so, then, 'listen to your gut'. Do you understand them? Are they in plain language that any reasonably alert individual would correctly understand? Or can they be interpreted in various ways? Press for clarity on these issues, in writing as appropriate.**



. . . Contractual Performance Criteria

- Are the performance expectations based upon poor actuarial and encounter data for Chemical Dependency treatment – i.e., data that is questionable and not well validated in your state or regional area? Are they based upon indicators that were derived from another state and locality that *may not be applicable* to your state or location . . . such as data drawn from an URBAN area, while YOU live in a rural area where the population is far flung and the geographical barriers to CD services are great? Check with your local Substance Abuse Provider Council. If the data are poorly derived, it could be a problem, and worth negotiating with the Health Plan!**



. . . Contractual Performance Criteria

- Do the performance measures, or do they not, mesh with your own experiences with the given population? HEED THESE SIGNALS. Example of a problematic criterion: 'Contract requires a 90% success rate at maintaining contact with individuals who are discharged from a detox unit, for a period of 60 days following discharge.' This criterion far exceeds the national norm, and flies in the face of the known data. ALSO, will you have to make some internal program adjustments to meet the performance criteria? Such as initiating follow-up aftercare calls with a high success rate? If so, be certain to recognize this and act accordingly, when negotiating your contract with the HMO.**



Because we no longer have 'forever' for treatment to work!



**Treatment + Good Outcomes =
Funding!**

Let's move on now, to the heavier aspects of professional change – how we DOCUMENT TREATMENT, and some of the creative ways that programs can contract with managed care companies.

Congratulations!

You have completed the second half of Lesson 1 in this course 3B. You may complete the short quiz for this lesson either now or later. To reach the quiz link, simply close this internet page and you will be returned to your Courses and Quizzes page. Click on Quiz 1 for Course 3B. To take it later, log in to your My Home Page and click the link for this course.

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 – your choice! To move on to the 2nd lesson of this course, close this page and click on Lesson 2, Course 3B (or return to your [My Home Page](#) later).

