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DEFINING MANAGED CARE

THE MANAGED CARE ENVIRONMENT

In ancient times, the psychiatrist assessed a patient's need for psychiatric services, developed a treatment plan, and charged a fee for the services provided to the patient. Insurance companies reimbursed the cost of the treatment as long as the services provided were covered benefits under the patient's health insurance plan and the patient was an eligible beneficiary (i.e., covered under the plan). This world may still exist somewhere.

As healthcare costs rose in the 1980s, managed care organizations came into being as a way to control expenses while still providing necessary care. Nowadays the vast majority of people are insured under some kind of managed care plan, administered by a managed care organization (MCO). In the days of fee-for-service medical insurance, the only managed care around took the form of the staff-model health maintenance organization (HMO), but today managed care comes in a variety of forms and combinations of those forms. Psychiatric services provided under managed care are now sometimes covered under mental health carveouts, administered by separate managed behavioral health organizations (MBHOs).

Prior to the implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008, an MBHO could function under an entirely different set of procedures than the MCO that contracted with it had for its medical and surgical coverage. Nowadays, coverage for mental health and substance use disorders must be equal to substantially all of the medical and surgical coverage, even though the mental healthcare may be administered by a separate entity. The parity applies to quantitative elements such as deductibles (there can't be a separate deductible for mental health or substance abuse care) and limits on the number of encounters covered and to nonquantitative elements such as formulary design or medical management standards that limit or exclude benefits based on medical necessity or medical appropriateness. Standards for provider admission to participate in a network, including reimbursement rates, are also considered to be part of nonquantitative treatment limitations that are not permitted under MHPAEA.

It is important to understand that the economic concerns of the purchasers of health insurance, primarily employers, are usually what determines how managed care plans are structured. Plans are restricted to fit what employers are willing or able to pay for.

MANAGED CARE MODELS

There are several basic models for managed care, and there are many combinations and variations of these models in operation today. The basic forms of managed care are distinguished primarily by their restrictiveness–both for the patient and for the psychiatrist.

Preferred Provider Organizations

Preferred provider organizations (PPOs) use a restricted network of clinicians who have agreed to provide services at reduced rates and often require preauthorization for care as well as other utilization management. The rate reductions generally take the form of a predetermined fee schedule or discounts on usual and customary fees. (The discounts average approximately 30 percent of the usual rate.) PPOs provide incentives for beneficiaries to use participating providers. When they use a member of the PPO they generally just have to pay a reasonably low co-pay; when they go to a physician outside the PPO they are only reimbursed for a percentage of the physician’s undiscounted fee, and there is usually a deductible that must be reached before this reimbursement kicks in.

Health Maintenance Organizations

Health maintenance organizations (HMOs) are often described as “prepaid health plans.” Historically the most restrictive of managed care models (and also the earliest model), HMOs usually require a referral from a primary care physician for any specialty care and mandate that patients use only a specific network of clinicians. The most common types of HMOs are staff-model HMOs and IPAs (independent physician associations). Physicians in staff-model HMOs are salaried. IPAs are physician-controlled groups that provide services to HMO members. The physicians retain their separate practices, but function as a group for the purpose of providing care to the HMO members. IPA members are paid on a capitated basis. Typically, there is no benefit payment if a patient chooses a non-HMO psychiatrist, except in emergencies. Times are changing, though, and some HMOs now offer point-of-service options.

Point-of-Service Plans

Point-of-service (POS) plans are a hybrid of the HMO and PPO models. POS plans usually have the core characteristics of HMOs, including utilization management and preauthorization requirements; a restricted network of clinicians; a primary care gatekeeper; and fixed-dollar copayments. However, a POS plan also includes an “out-of-network” benefit that operates like a PPO. A POS plan allows a patient to choose a nonparticipating physician and provides a reduced level of benefits for such services. Because of the difference in benefit levels and coinsurance requirements, patients have a strong incentive to choose providers within the network.

Managed Indemnity or Managed Fee-for-Service Programs

The managed indemnity, or managed fee-for-service, program is the least restrictive managed care model, but it generally still requires precertification for some or all procedures and treatment settings (e.g., inpatient admission). If not combined with some other kind of managed care program that limits access to certain providers, patients are usually able to choose any psychiatrist as long as the treatment is preauthorized. The amount of services is restricted only by the limits stated in the benefit plan document.

Provider Sponsored Organizations (PSOs)

These provider groups, PSOs, are usually regional associations that include health systems as well as individual physicians and other healthcare providers and serve as integrated delivery systems. They are both the insurers and providers of health services. PSOs often provide healthcare for government-sponsored programs such as Medicaid and Medicare.

These managed care models and all their variations and combinations may be used by commercial healthcare insurance companies and for government sponsored programs such as Medicare, Medicaid, and workers' compensation. They may also be used by disability carriers.

EMERGING MCO STRATEGIES

As the managed care market evolves, many of the MBHOs are implementing, or considering implementing, some of the strategies currently used by the larger MCOs. These include:

- Pay for the episode of care—This is similar to what's done for inpatient care with DRGs (diagnostic related groups). The physician contracts for a flat fee to care for an episode of care such as psychosis.
- Preferred, or select, panels, which may be selected based on performance measures or special expertise (e.g., experience in the treatment of eating disorders).
- Recommendations to certain providers may be based on the MBHO's internal measures (e.g., efficiency, high volume, easy access, etc.)
- The development of disease management models to assist physicians in organizing their delivery of care to certain disease populations. These may include rating scales, protocols, follow-up plans, and telephonic case consultation.
- Pay for performance—This is still in its infancy, but MBHOs (following the example of Medicare) are studying how to obtain data to reward quality care.

EVALUATING MCOs and MBHOs

Currently, mental health services are often administered by managed behavioral health organizations (MBHOs) with whom MCOs contract for their members' mental health care. An MBHO is just an MCO that only deals with mental health care—that administers the mental health services that have been "carved out" of the MCOs complete healthcare policy that it sells to purchasers. As a psychiatrist you will likely be contracting with the MBHO carveout rather than with the MCO.

Clearly, not all MBHOs are alike. Just like MCOs, each establishes its own policies and procedures. Each develops a set of practice guidelines. Each has its own policies regarding appeals. Each has a separate contract with providers.

The following questions may help you to evaluate whether or not you wish to join a particular MBHO network:

1. Who owns the MBHO? Has it recently gone through a merger or acquisition process that could hinder its administrative functions?
2. Is the MBHO financially solvent? Many companies have taken on a high debt load as mergers and consolidations continue. Financial problems within the MBHO could mean your bills won't be paid on time–if at all. Ask to see recent reports, budgets, and audited financial statements. When dealing with a newly formed MBHO, ask about the founders and financial backers. Check to see if the company has at least a B+ rating with A.M. Best (www.ambest.com).
3. What is the administrative structure of the MBHO? Find out who the medical director is and how he or she fits into the chain of command.
4. The MBHO should have written policies and procedures for grievances, appeals, utilization review, selection and credentialling criteria, claims filing, and payments. These are usually contained in the provider handbook. You should have a copy of this that you've read carefully before you sign any contract.
5. What is the MBHO's payment structure and what services does it cover? This may be in the MBHO application. If not, find out.
6. What practice guidelines does the MBHO use? Any practice guidelines should be compatible with the guidelines developed by the APA (see Chapter 39).
7. Which employers in your locale contract with the MBHO and how many potential patients do they represent?
8. How does the MBHO market itself?

9. With which hospitals does the MBHO contract? Are you required to have admitting privileges at them?
10. What is the annual disenrollment rate of providers? Can the MBHO terminate you without a statement of cause?
11. Is the MBHO accredited by external organizations, such as the National Committee for Quality Assurance (NCQA)?
12. Is the MBHO insured, and what are the limits of the insurance?

Requesting answers to these questions not only allows you to make an informed decision as to whether to join the MBHO's network, it also allows you to establish a relationship with the MBHO's staff to see how you would feel about working with them on a regular basis.

It is important for psychiatrists to keep track of which networks they belong to. When a problem arises with a claim, APA members often find it helpful to contact the MBHO's medical director directly regarding their concerns.

MCO ACCREDITATION

The National Committee on Quality Assurance (NCQA) began accrediting managed care organizations in 1991 and began accrediting managed behavioral healthcare organizations in 1997. NCQA currently reviews and scores plans against more than sixty different standards.

As of the end September 2014, forty-eight MBHOs had received full NCQA accreditation, good for three years. These accredited plans were for commercial products as well as for Medicare and Medicaid plans . If you visit the NCQA website (http://reportcard.ncqa.org/mbho/) you can find the most current information about which organizations have been accredited and which are in the process.

NCQA also developed a set of performance measures that can be used to compare health plans, the Health Plan Employer Data and Information Set (HEDIS). To learn more about NCQA in general, visit their website, www.ncqa.org

APA PRINCIPLES FOR MBHOs

In September 1997, the APA approved a Resource Document entitled "General Principles for the Operation of Managed Mental Health and Substance Abuse Organizations," which is included in Appendix T.