

Major Dimensions of Managed Behavioral Health Care Arrangements

Level 3: MCO/BHO and Provider Contract

Introduction

To understand how managed care operates in a state or locality it may be necessary to collect organizational, financial and clinical management information at multiple levels. For instance, in the State of Florida, the public sector purchaser (state Medicaid authority) contracts with MCOs (managed care organizations, in this case HMOs) which in turn subcontract with specialty BHOs (behavioral health organizations) to manage and provide behavioral health services to Medicaid recipients. These BHOs contract with a network of service providers to deliver mental health care to HMO enrollees. In order to capture the major dimensions of a Florida managed care arrangement, then, a multi-layer survey instrument is necessary. This instrument must capture a variety of dimensions at three levels: (1) purchaser to MCO; (2) MCO to BHO; and (3) BHO to service provider network. For this purpose, we have developed a set of three instruments (Levels 1, 2 and 3). Depending on the managed care configuration in a particular state or locality, either two or three Levels will need to be completed.

The unit of analysis for this Level 3 instrument are the contracts between the MCO/BHO and the service providers in their network. It is likely that the MCO/BHO is contracting with a number of providers – both individual practitioners and institutional providers. However, MCO/BHOs tend to use standard contracts so that a contract for each provider type (e.g., general hospital, mental health center, etc.) will probably be representative of these arrangements (check with the MCO/BHO). If provisions for medical necessity, benefit determination, and accountability vary by provider type, then attach separate sheets that are labeled by provider type.

This is a point in time analysis. Data are collected on the contracts in force at the time of this survey; from the parties to that contract; and, if necessary, from other relevant parties (e.g., state Medicaid authority). Much of the information will be gleaned from telephone interviews with the parties, however, the instrument has been designed so that portions may be submitted to MCO/BHO officials for completion. Review of the contracts as well as other documents (e.g., MCO/BHO Policy and Procedure manuals, etc.) is suggested but not required to complete the survey. Those who seek a more in-depth understanding of the dimensions of managed care (i.e., the "how" in addition to the "what") will want to review the contract and other documents in advance of interviews with the parties.

This survey attempts to specify clinical and financial incentives in a way that will allow meaningful cross-plan and cross-state comparisons.

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SERVICE SYSTEM/PROVIDER NETWORK COMPOSITION

Definitions:

- **Provider** - A physician, hospital, group practice, nursing home, pharmacy, or any individual or group of individuals which provides a health care service.
- **Provider Network** - a group of physicians, hospitals, laboratories, or other health care providers who participate in a managed care plan's health delivery program. Providers agree to follow the plan's procedures, permit the monitoring of their practices, and may provide certain negotiated discounts in exchange for a guaranteed patient pool.

(1-2) Provider Type

Rationale

It is important to be able to compare plans in terms of the composition of their provider networks. This is one way to assess the richness of the service network, although it is an imperfect measure of quality of care.

It is important when asking about numbers of provider types in the network to focus only on those providers who have received referrals. It is not uncommon for MCOs/BHOs to sign up an extensive list of providers but use a "core" set of providers for the majority of their referrals. Assessments based on the more extensive list may be misleading.

Definitions

(1) Individual Providers

- **(a) Adult Psychiatrist** - physician specializing in psychiatry (MD)
- **(b) Child Psychiatrist** - physician specializing in child psychiatry (MD)
- **(c) Adult Psychologist** - licensed therapist specializing in adult psychology (Ph.D.)
- **(d) Child Psychologist** - licensed therapist specializing in child psychology (Ph.D.)
- **(e) Social Worker** - licensed social worker (MSW)
- **(f) Certified Substance Abuse Counselor** - licensed SA Counselors (Masters Level)
- **(g) Nurse** - Certified Nurse Practitioner (RN)

(2) Institutional Providers

- **(a) Licensed Inpatient General Hospital** - any general hospital
- **(b) Licensed Inpatient Psychiatric Hospital** - specialty psychiatric hospital
- **(c) Licensed General Hospital Outpatient Clinic** - outpatient clinic of a general hospital
- **(d) Licensed Partial/Day Hospital Program** - a partial/day program within any hospital
- **(e) Residential - Adults with SMI** - any residential program licensed to serve Adults w/ Severe Mental Illness

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- **(f) Residential - Adults with Substance Abuse Disorders** - any residential program licensed to serve Adults w/ Substance Abuse Disorders
- **(g) Residential - Children/Adolescents with Severe Emotional Disturbances** - any residential program licensed to serve Children/Adolescents with Severe Emotional Disturbances
- **(h) Residential - Children/Adolescents with Substance Abuse Disorders** - any residential program licensed to serve Adolescents w/ Substance Abuse Disorders
- **(i) Licensed Outpatient Psychiatric Clinics or Mental Health Center** - any licensed clinic or health center serving persons with psychiatric disorders in an outpatient setting
- **(j) Licensed Intensive Outpatient Rehabilitation Programs** - as above, providing intensive rehab
- **(k) Community-Based Wrap-Around Programs (Children)** - non-traditional, individualized services such as transportation to doctors' appointments
- **(l) Licensed Mobile Treatment/Crisis Teams** - teams of MH professionals providing crisis intervention in the community to individuals with psychiatric and/or substance abuse disorders
- **(m) Licensed Case Management Programs** - programs providing clinical case management to populations with psychiatric and/or substance abuse disorders
- **(n) Agency-Organized Drop-In Center or Social Club** - agency-organized center, providing social support, recreational activities, and/or social skills training (clubhouse)
- **(o) Peer Drop-In Center or Social Club** - peer-run center, providing mutual support, recreational activities, and/or social skills training (clubhouse)

Potential sources

- MCO/BHO contract
- MCO/BHO Directory of Providers
- MCO/BHO

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(3-6) Medical Necessity and Benefit Coverage and Determination Procedures

Rationale

The benefit plan is not a good guide to understanding what services are available to enrollees. Medical necessity criteria are used by the plan to determine which services will be authorized. This section documents the definition of “medical necessity” for behavioral health services, and includes information on how the MCO makes these determinations (including specific mechanisms).

Definitions

(3)

- **Medically Necessary** – Services or supplies which meet the following tests: they are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; they are provided for the diagnosis or direct care and treatment of the medical condition; they meet the standards of good medical practice within the medical community in the service area; they are not primarily for the convenience of the plan member or the plan provider; and they are the most appropriate level or supply of service which can safely be provided. This standard is becoming the most important one for providers to focus upon.

(4)

- **ASAM Criteria** - American Society of Addiction Medicine criteria for placement and discharge for substance abuse treatment services.
- **Clinical/Treatment Protocols** –Practice guidelines designed to aid clinicians in making decisions about appropriate treatment and level of care for a particular disorder.

(6)

- **Appeal** - A formal request by a covered person or provider for reconsideration of a decision such as a utilization review recommendation, a benefit payment, or an administrative action.

(7)

- **Utilization Review** - a formal assessment of the medical necessity, efficiency, and/or appropriateness of services and treatment plans on a prospective, concurrent, or retrospective basis.
- **Utilization Management** - a combination of utilization review and administrative case management that uses principles of medical necessity, appropriate level of care, and cost-effectiveness.
- **Prior Authorization** – a review to determine if proposed treatment is medically necessary conducted by an internal or external reviewer *before* services are provided. Services must be authorized by the responsible entity in order for payment to be made.

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- **Concurrent Review** - A routine review by an internal or external utilization reviewer during the course of a patient's treatment, the aim of which is to determine if continued treatment is medically necessary. This mechanism is most frequently used for inpatient, residential, and partial hospitalization treatment, though it is becoming more frequent for outpatient as well.
- **Retrospective Review** - A review that is conducted *after* services are provided to the patient. The review focuses on determining the appropriateness, necessity, quality, and reasonableness of services provided.

Potential Sources

- MCO Contract
- MCO Policy and Procedures manual

(8-9) Accountability

Rationale

Having a fixed point of accountability has been suggested as a primary strength of managed care systems. Here we attempt to understand the range of sanctions available to the purchaser in the course of their contract compliance and quality assurance oversight of their vendor.

Definitions

- **Sanction** - penalty imposed on vendor by purchaser; may include reduction in payment, suspension of new enrollment, withholding of shared savings, imposition of a corrective action plan, or termination of contract at the extreme end of this continuum.
- **Non-Performance** – Failure to comply with performance standards specified under a contract.

Potential Source

- State Medicaid authority
- MCO Contract

THIS IS THE END OF LEVEL 3.