Benefits Management Of Public Programs

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The Criterion Health Management Briefing Series provides resource materials that allow quick overviews of the major factors influencing the industry as well as reference sources for more intensive investigation.

Most of us are familiar with the term managed care as it applies to health insurance. By its use it connotes both bad images such as pre-approval to access care as well as positive trends as it applies to increasing insurance coverage of cost effective preventative services and disease management programs for chronic conditions.

Most people do not know the extent of organization and regulation impacting how managed care evolved into its current state. The federal government became involved in establishing protections and guidelines to assure managed care protected the lives being "managed". The regulations imposed on health insurers and states was codified in the Balanced Budget Act (P.L. 105-33) in 1997 and has evolved significantly over the years inclusive of many new protections in the new Patient Protection and Affordable Care Act (PL 111-148).

Specific guidelines and checks and balances are in place dealing with issues such as:

- Plan member eligibility
- Provider eligibility and credentialing
- Provider contracting methodologies
- Provider orientation and training
- Plan member plan awareness
- Provider network access and scope of services
- Scope of covered services
- Plan member grievance and appeal procedures
- Provider grievance and appeal procedures
- Performance improvement methodologies
- Utilization review methodologies
- Financial and risk management methodologies
- Information technology requirements
- Recordkeeping requirements
- Contractual compliance and plan member safety

The requirements have become standardized in all 50 states insurance requirements and they significantly impact the way all public insurance programs such as Medicare and Medicaid perform. In Medicaid and Medicare the procedures require independent external reviews at least every two years for venders performing public benefits management. The guidelines interpreting the laws have been codified and all independent examiners must conform to common guidelines and share their findings to assure performance improvement and compliance to the intent of the act. These External Quality Review Organizations (EQROs) operate from guidelines determined by the Center for Medicare and Medicaid Services (CMS). Therefore it may come as no surprise that we are seeing managed care become more widely utilized for managing other public programs.

One of the areas seeing an explosion in the use of managed care principles is child welfare. According to a 2005 Child Welfare League of America survey, 34 states responded that they are experimenting with performance based contracting for one or more child welfare services and nearly half of those initiatives include bonuses or penalties linked to key performance indicators or outcomes. In 2010 twelve states have shifted to statewide performance contracting, with several others beginning the process for statewide coverage, i.e. Indiana and Washington states. Federally the Administration for Children and Families of the US Department Health and Human Services amended the Social Security Act to create a formal methodology for Child and Family Services Reviews (CFSRs) for states utilizing managed care practices.

The CFSR process has much in common with the health insurance EQRO process. The elements of a CFSR are:

- Safety (in EQRO outcomes monitoring is different, but similar in process to how outcomes for Child Safety, Placement permanency and Child and Family Well Being are measured as outcomes in welfare system)
- Permanency (see above)
- Child and Family Well Being (see above)
- Information system (in EQRO)
- Care review system (very similar review process to utilization management)
- Quality assurance system ((in EQRO Performance Improvement monitoring)
- Staff and provider training (in EQRO)
- Service array (in EQRO Network and Covered Services)
- System change process (in EQRO Performance Improvement methodology)
- Credentialing (in EQRO)

As states outsource Child Welfare Performance Contracting, opportunities and experiences similar to how behavioral health was "managed" twenty years ago are starting to surface. Criterion Health has been involved with behavioral health and disease management managed care since its inception. What we are seeing in child welfare is very familiar. What follows are some ideas for consideration as the move to outsourced child welfare performance contracts moves forward:

Provider Organization Alliance:

States suffer the same dilemma service organizations do; doing something new and unfamiliar means we interpret based from what we know. Initial Requests for Proposals from states seem loaded with historic process regulation elements when they are seemingly asking for organizations to step up, take risk and do business in a new way and be paid for outcomes or specified results. It's hard to do that if you must maintain service processes the old ways that were not efficient, effective or satisfactory and therefore led to the request for new ways of doing business?

Providers considering becoming the new hub Master Contractors for performance based contracting need to overcome their pasts as well. Specifically consider:

- Minimize thinking about old scope of services and "catchment" areas
- Seek alliance with technology partners who can bring strength to benefit management. (Too often we see horizontal provider alliances, but no skill or efficiency to administering the benefits.) The CFSR emphasizes resource management, services planning, performance improvement and compliance to both laws and contract outcomes. Seek partners with expertise in those areas.
- If possible, create a new limited liability corporation (LLC) to contain the risk of the contract. Private managed care organizations and all insurance companies wrap their risks inside separate corporations for each "plan". An LLC corporate model can do that for you in this arena. Note: LLCs can also receive nonprofit status from the Internal Revenue Service.

Administrative Service Organization:

In every state, when the "dust clears" a new centralized (usually regionally) administrative services organization (ASO) is created. At its minimum it must:

- Plan, organize and oversee a service network
    - Conduct needs assessments and gap analysis
    - Contract, orient and maintain a provider network

    - Attend to provider grievances and appeals
    - Include providers in services evaluation and planning
    - Maintain a formal training program
    - Encourage and validate use of evidence based practices
    - Implement a formal performance improvement mechanism in the network
    - Manage claims to professional standards
- Orient and service plan members
    - Certify eligibility
    - Orient to services available
    - Provide ongoing information and prevention services
    - Attend to grievances and appeals formally and systematically
    - Assess access, satisfaction and impact of services received
- Manage and monitor resource utilization
    - Have a Utilization Management plan based on professional standards (research, peer guidelines or statistics)
- Maintain electronic documentation
    - Respond timely and accurately to data and report needs
- Maintain an active compliance program
    - Proving compliance to applicable laws
    - Proving compliance to contract requirements

The ASO may be lightly staffed, and may outsource elements such as afterhours call centers or claims administration but it must show how it assures all functions are “managed” and are uniform in application.

Outlier Based Resource Management

At its core the new entity is about resource management. The right service needs to promptly get to the needs of an individual being served. Historically resource management has been based on either commonly known research findings, standardized instruments rating scales or professional guild based guidelines. Increasingly expectations are emerging that we need adequate current knowledge of resources that we manage true statistical outliers.

The practical basis of an outlier management system is that a benefit management entity only has so many human resources available to help managed plan members. Those people efforts should go to the most needy, so focusing on the service experience of the most needy members allows increased services coordination and experience oversight.

The requirement of such an approach is a timely, accurate information system, one that ideally builds decision trees into its documented logic, such that care

coordinators can see the likely list of needed services against a plan members stated issues.

Professional Performance improvement

The CFSR process, just like the EQRO process in insurance requires very formal processes be utilized for assuring an ever improving panel of service providers. These requirements may be the single most different issue for providers. A network of diverse providers by necessity must be handled differently than a staff of employees. What has evolved, and is defined and supported in the CFSR process codifies a LEAN type services improvement process.

Professional Compliance

The Master Contractor is legally filling the role of government. Liability is attached. The Master Contractor must verify all claims made are true and accurate. Responsibility to prove compliance to both the laws governing service es as well as proving compliance to the elements of performance specified in the contract are required. (Additionally the Board of Directors will have goals that must be monitored and evaluated.)

A formal Compliance Officer and a department are most likely required. This entity must conduct site visits and sample performance and proof of documentation of compliance.

Program Evaluation for Stakeholder Support

These system changes are dynamic. They are at once, both professional improvements and political. It is in the Master Contractors best self interest to organize a formal program evaluation system and to measure on an ongoing basis proof of:

- Access to services
- Acceptability of services
- Impact of services
- Value of services delivered

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