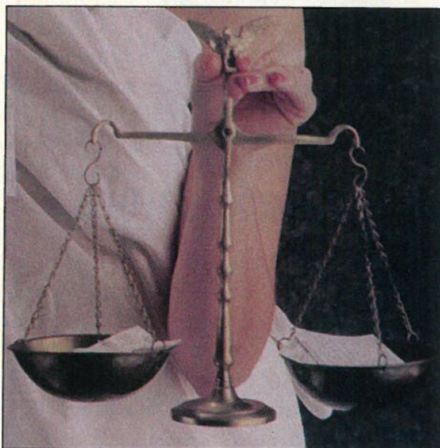
Risk Shifting and Managed Care

Should EAPs be concerned?


Joe Griffin

The idea of being financially at risk is nothing new to EA professionals or programs. Like HMOs, EAPs have estimated utilization and given purchasers a per capita rate for services. If the utilization is higher than estimated the EAP can lose money. If it is lower than expected, there can be a profit on the contract.

There is an increasing trend in managed behavioral healthcare plans to shift risk toward providers of mental health and chemical dependency services. Although as EAPs we have some familiarity with this model, we can learn much from our medical colleagues who have been operating in managed, at risk or capitated systems for several years.

When HMOs, the most familiar type of managed care, were first introduced in the 1920s and 1930s, they were attacked by organized medicine in the press and in the courts as immoral forms of socialized medicine. But the demand for accountability has risen. Employers and employees alike are being forced to deal with escalating healthcare costs. In an era so preoccupied with costs, managed care has the decided advantage of uniting concern for cost and quality in one organization, and ultimately in one clinician.

RISK SHARING HISTORY. Risk sharing techniques are not new. They serve as the mainstay of cost containment for many HMOs and managed care plans in the medical arena. For instance, the most common approach to risk sharing among IPAs is to withhold 15 percent to 30 percent of the provider claims from approved payment. This amount is placed in a risk pool to act as a buffer against unanticipated price increases or excessive utilization in the future. An increasing number of managed care organizations, including managed behavioral healthcare firms, have implemented risk sharing and directly capitate their groups or individual providers.

In some plans, providers may be targeted for further review and increased withholds when their practice pattern statistics rise 15 percent to 25 percent above their specialty averages. An example of one pattern statistic being used in the behavioral healthcare area is that 80 percent of outpatient psychological treatment is expected to be completed within eight to 12 sessions. Above average profile data may indicate a more difficult case mix. However, in absence of such documentation, outlier providers can be warned, monitored for a period, and required to repay the plan for the difference between peer practice statistics and their performance.

We are seeing managed behavioral health plans and EA programs where groups and individuals are at risk for EA services as well as treatment. The ability to assume risk is often being used as one way to sort through proposals to provide services. Those who are willing to assume risk are considered; those who are not, are excluded from the process. There are EAPs that contract for assessments at case rates. Assessments are reimbursed at a set rate whether they consist of one or three sessions. There are provider based managed care programs that are using case rates for all psychiatric services, contracting directly with employers in an exclusive provider agreement (EPA).

Some plans put groups of psychiatrists, who are responsible for precertification for all psychiatric and chemical dependency inpatient admissions, at risk. There are managed behavioral healthcare organizations that are utilizing withholds. Those willing to accept a withhold are assuming a major portion of the risk, even though they control the consumption of the services. It is important to realize that the responsibility for, and indeed the interest in, utilization review shifts with risk. If you are at financial risk, you must be able to control utilization.

SPECIALIZED INSURANCE. By accepting risk some providers are acting as small specialized insurance companies. Solo practitioners are increasingly choosing to practice in groups, not only because of the administrative burden of managed care, but also to enable them to handle "going at risk" and providing utilization review. As we have seen on the medical side of the house, increasing at-risk and capitated business has important administrative and operational implications. Providers must ensure computer capability to track services and claims, implement more effective cost accounting systems and adequately reserve for incurred but not reported (IBNR) claims.

Risk assumption should be materially offset by creating a bonus for providers based on a portion of the savings. Once a savings pool is determined, the providers might be paid on a pro rata basis. This sharing of savings is one way to equalize risk sharing. It is difficult to implement one without the other.

Prepayment, capitation, and risk shifting, the hallmarks of managed care, obviously create financial incentives very different from fee-for-service. By rewarding reduced expenditures, prepayment creates the danger of undertreatment. By contrast, fee-for-service and productivity-based compensation creates the danger of overtreatment by rewarding the clinician for providing and charging more.

By Tamara Cagney

DIFFERING VALUES. Managed care and fee-for-service are not only economically competing forms of healthcare delivery. The two systems balance basic values very differently. Managed care treats cost effectiveness and reducing waste as ethical concerns and places greater value on the prudent use of resources than it does on freedom of choice. While individual fee-for-service clinicians may be superbly attentive to cost effectiveness, as a system, fee-for-service neglects cost considerations. This is why it is disappearing so rapidly in its pure and unmanaged form.

The unmanaged system implicitly operates on the assumption that resources are effectively unlimited. Free market *laissez faire* determines the allocation of resources. In contrast, the managed care system posits a world of finite resources in which explicit choices must be made.

The key to managed care is an attempt to deliver an acceptable level of care to as many individuals as necessary with this finite resource. The rub here is "acceptable." This does not mean optimal. Most of us are used to referring to or providing optimal levels of care. Clinicians are now being asked to deliver less care than they know how to provide. Organized labor is learning that it did not negotiate for specific levels of care, such as 28-day determined length of stay treatment programs, but rather for an acceptable level of care.

The provider payment strategies of managed care plans transfer financial risk to create economic incentives to control costs and keep service usage at acceptable rather than optimal levels. For several years providers tended to be the unsophisticated partners in managed care plans. The financial pressures, and ethical and legal dilemmas for the provider caused by managed care have been greater than any of us would have anticipated.

The equation is supposed to be that providers will receive an increased market share (more referrals) for their agreement to discount rates and accept increased accountability and financial risk. This equation should result in stable patient populations and revenue streams.

Accepting this agreement presents both business and ethical risks for the provider. The chief business risk is the provider accepting specified rates of reimbursement (increasingly capitation), and may not have acquired the same degree of control over its costs and utilization as the payor has over its revenues. The provider may find itself with a full practice or full beds and an empty bank account.

The "volume" argument (that managed care will increase patient volume) is widely espoused and accepted, but satisfactory results are rarely delivered. If payors are able to deliver more predictable patient flow to providers there will be a change in the payor-provider relationship. There will be more risk sharing and profit sharing and all parties will work together in the same environment toward the same end—efficient, high quality healthcare.

Many providers now have a record of experience in managing

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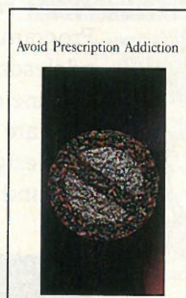

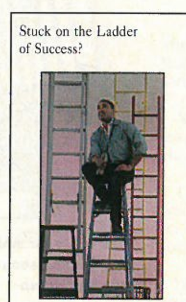

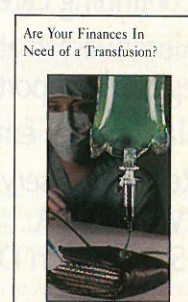

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managed care contracts. Desirable network providers are more selective about the terms they will accept and the nature of the risk they will assume. Financial promises are compared with actual experience. Enrollment is evaluated in terms of new patients and the conversion of existing patients. Contracts which have not afforded sufficient volume or revenue are either not being renewed under the same terms or not at all.

At the same time, insurers are scrutinizing their experience with providers. The popularity of providers is no longer sufficient for membership in a network if their utilization experience is unmanageable. Managed care organizations have developed sophisticated tracking capabilities that can now identify individual providers whose practice patterns deviate from community norms. Managed care organizations are also taking measures to validate discounted fees against usual and customary charges. Armed with this information, they can take action to counsel; affect modification; and if necessary, terminate arrangements.

Current provider reimbursement arrangements are subject to revision as computer technologies allow for more detailed tracking of utilization and comparison with standard treatment protocols. Use of withholds, incentives and risk sharing will be combined in new ways with fee-for-service, per diem, discount and case fee reimbursement methodologies. Particular attention will be focused on the utilization of outpatient services to ensure control in this relatively unmanaged area. Competition in the provider community will drive alternative reimbursement methodologies, as will employer intervention.

All of these risk contracts, prospective payment and capitated delivery models have the potential to create hazards for the patients. Policies and procedures designed to reduce utilization and restrict access to care have contributed to the ever increasing atmosphere of fear and apprehension about the quality of healthcare. Do discounted rates really

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Under some capitation programs, there may be a tendency on the part of providers to underserve the population in order to maximize bonus payments. Thus, the UR system should have checks and balances that limit access to care while assuring that patients are getting quality care.

Managed care clearly creates double agent conflicts, particularly as more risks are shifted to the provider. The provider stands to benefit if less is spent rendering care. Clinicians working with utilization management may have a vested interest in cooperating with the insurer to maintain referrals, but the relationship is generally less cooperative than when the clinicians are at risk.

Although case reviewers often have strong clinical backgrounds and values and may wish to act as collaborative consultants, utilization review is considered essentially adversarial. The principle underlying utilization review is inspection—what Berwick described as the "bad apple" approach to quality improvement. In a climate of adversarialism and inspection the clinician may be tempted to "fudge" the information provided to the insurer, even if the action involves deceit, in order to act as the client's advocate.

MIXED MOTIVES. Given that mixed motives in both fee-for-service and managed care systems cannot be avoided, the ethically crucial question is how double agent conflicts are actually resolved. Being ethical entails being skilled in identification, analysis and resolution of ethical problems that arise in the care of particular clients. Clinicians are not currently given training in these skills and discussion of these issues is still rare. To some extent, the familiar principle of informed consent provides a useful aid for this assessment. As a guideline, if a clinician is not prepared to describe the terms under which he or she is treating a client, including financial incentives and restrictions on referrals, then the system is unethical.

From the providers' perspective it is very important for the system to be financially balanced; that is, the provider must be sure the system will, over time, provide a reasonable incentive to manage healthcare. Providers must assure themselves that the proposed managed care system will enable them to practice appropriate healthcare.

Provider and plan have to create a joint effort to control the consumption of healthcare services. There must be shared appreciation of the finite nature of the resource. Each individual provider is concerned about its financial survival as are the managed care organizations. Poorly negotiated plans can eventually create a serious financial problem for the provider and, in the long run, jeopardize the managed care organization as well.

Only the provider can effectively control the utilization of healthcare services, although others will try to restrict the scope of treatment. Efficiency will share the spot light with quality as the networks mature. Few providers are ever trained to deliver healthcare in an efficient manner. Few therapists can identify at all with the idea of being "efficient" clinicians. Much time is spent during training on diagnostic techniques and treatment, but little emphasis is placed on how those techniques affect the cost of healthcare.

The bottom line success of a managed care plan will be heavily dependent on

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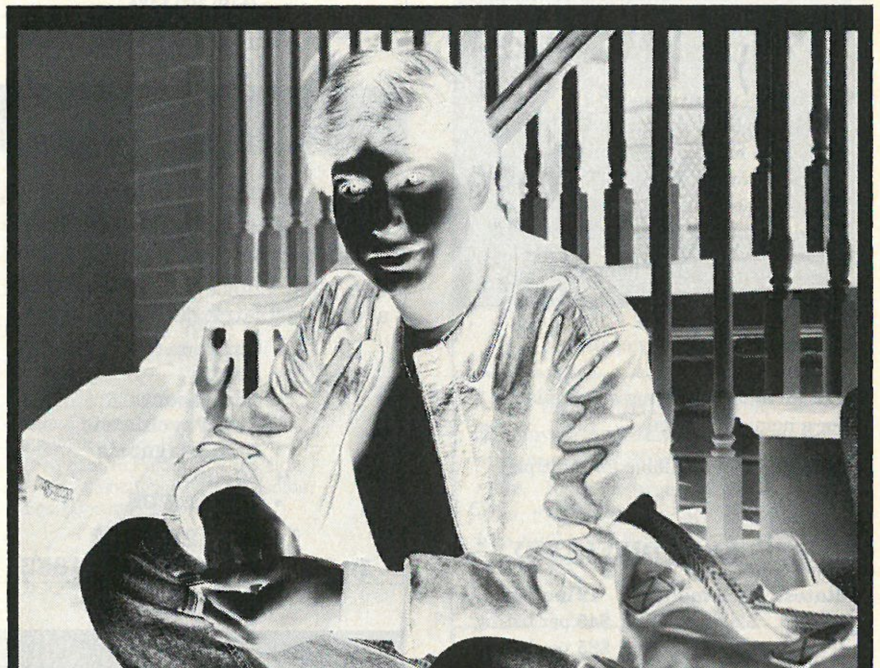

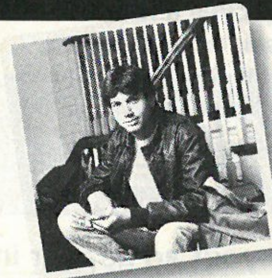

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the control of provider behavior. As a result, it is mandatory to integrate financial controls into provider practice patterns. Individual providers need to be held accountable for appropriate behavior. We will see more financial incentives and disincentives tied to individual practice patterns.

It remains to be seen whether or not selected providers and purchasers will be able to make the necessary compromises with each other in order to develop win-win scenarios for the entire healthcare industry. This is the only way managed care will work to balance out competing interests in cost management, quality care and freedom of choice. The "rules of the game" will need to be redrafted by payers, purchasers and providers so that both risks and gains are more equitably spread among the major players.

EVALUATION. Ethical evaluation of managed care would be simple if the amount of care required to correctly treat psychological and chemical dependency problems was known. Unfortunately, the current state of the science/art does not provide that information. Given that many areas of the field have no strong scientific foundation, or even a strong professional consensus, assessing the strengths and weaknesses of managed care vs. fee-for-service is very difficult. In these circumstances, the debate is predictably anecdotal and passionate. There are horror stories to be told by both sides.

Where professional consensus is lacking, incentives have powerful influence over clinical judgement. Wennberg has demonstrated that when strong scientific agreement exists regarding proper care—as it does for hip fractures and hernias—relatively little variation occurs in treatment patterns from region to region.

But for issues that lack scientifically based consensus, like long-term hospital treatment of adolescent conduct disturbance, treatment of a relapse prone addict or of personality disorders, the incentive system will have a significant impact on treatment planning.

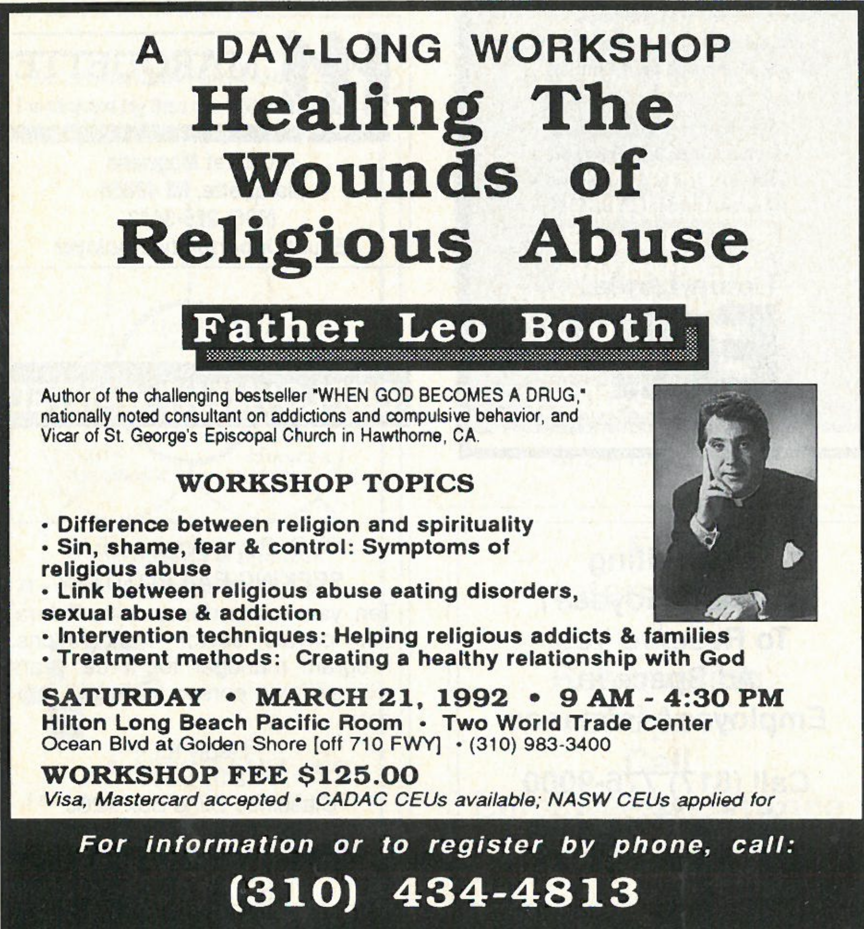
The most serious ethical failings in this area for EAPs and clinicians would be to mistake opinion for knowledge, to deny the extent of uncertainty in behavioral mental health treatment and to insist stridently on a particular point of view instead of supporting the quest for stronger scientific grounding.

As employee assistance professionals, it is vitally important that we stay abreast of the financial and ethical dilemmas these rapidly evolving systems pose for the providers to whom we refer.

Unfortunately, managed care is seen by many as the last chance for a competitive free market system. We must manage the system if it is to survive. But we must manage risk in a realistic way that does not damage providers.

It is crucial that we support efforts to establish standards of practice. It is also crucial that we, as employee assistance professionals, advocate good quality providers within the system. We are only as good as our referral resources. EA

Cagney is the executive director of Health Matters and can be reached at 2324 Santa Rita Road, Ste. 10, Pleasanton, Calif. 94566. A complete bibliography is available upon request.



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