Creating an Overnight Success in Nine Years

Patience, preparation crucial to advances by Pa. provider-based MBHO

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Provider-owned managed care companies aren't so unusual anymore, but they still face large numbers of critics who don't believe that providers can manage themselves — or care — effectively. Community Behavioral HealthCare Network of Pennsylvania set out to prove the critics wrong in a long journey to "overnight" success.

Getting started

Community Behavioral HealthCare Network of Pennsylvania (CBHNP) was founded in 1994 by a group of more than 100 mental health and addiction providers in Pennsylvania. The idea came from forward-thinking providers who were members of the Pennsylvania Community Providers Association (PCPA). A primary impetus was the announcement that Pennsylvania was moving to managed Medicaid (known in the state as HealthChoices).

The fear among community providers was that large, out-of-state, for-profit managed behavioral healthcare organizations (MBHOs) would swoop into the state and take needed dollars from the community. In times when the economy is tight, every dollar is needed for service. As mission-based community providers, the group felt something must be done to protect services and ensure that consumer needs were met.

Structured as a taxable, not-for-profit membership corporation, the CBHNP mission was and is to gain managed care market share in a manner to manage care effectively *and* find ways to decrease administrative costs, maximizing dollars to care. The new corporation created a dues structure for provider members, raised funds, and embarked on several years of infrastructure building and provider training.

CBHNP contracted with Managed Networks of America, a management services organization, to provide additional leadership in an effort to ensure that national standards and expertise were injected into the local community behavioral health effort.

Navigating hurdles

CBHNP was sure it was a great idea: community providers effectively managing care and increasing dollars to service. Only one problem existed — there were no takers.

Payers were clear. It was a great idea that someone (meaning someone *else*) should try. CBHNP was just too risky. Where is the history? Where are the financial reserves? Besides, can providers really manage care?

There were many detractors. Some said providers, once given free rein, would randomly increase services, offer no management, and eventually bankrupt the system. To community providers, who for years had managed services under program funding and limited budgets, this appeared counter-intuitive. But the critics were insistent.

In addition, the competitive bid process often eliminated CBHNP from the outset. Requests for proposals (RFPs), often created by consulting firms, including the obligatory questions

such as: “List your top five contracts in terms of managed care revenue”; “List three states in which you currently provide like services”; and so forth.

There were only so many creative ways in which CBHNP could say “none.”

The break

The first major break for CBHNP came in late 1996. BlueCross Northeast Pennsylvania desired a new partner for its health maintenance organization (HMO) business, First Priority Health (FPH). Through local relationships built by community providers, CBHNP gained access to decision-makers. Through a series of meetings, a deal was struck: CBHNP would provide FPH with a regional referral center for member services, utilization management, quality improvement, and associated managed care services.

CBHNP had limited time to implement. If the regional referral center did not open by January 1997, the opportunity would close and the current MBHO vendor would be renewed. Belief number one in provider-based managed care organizations: *Never let an opportunity go by; it will never come again*. With the help of staff from local providers, the phones began ringing at 12:01 a.m. on Jan. 1. CBHNP had arrived, roughly three years after its inception.

FPH later moved this contract to a shared-risk arrangement. While a scary proposition for community providers, it had to be done. Ultimately, if the network is not willing to partner on the risk for medical expenditures, then the network is not truly a partner. CBHNP began its first risk-bearing contract, paving the way for several other program expansions with BlueCross. Today the contract covers nearly 600,000 lives in both the HMO and indemnity products for BlueCross in 13 Northeast Pennsylvania counties.

Pennsylvania Medicaid opportunity

Pennsylvania HealthChoices was, and continues to be, rolled out on a regional basis in the Commonwealth: Southeast, Southwest, Capital Area, etc. Within HealthChoices is the concept of the county right of first opportunity; that is, the program goes from the state Department of Public Welfare (DPW) to the county to manage. The county can then refuse the offer, turning it back to the state, or accept the contract (and risk).

To accept, however, the county must meet numerous stringent operational and financial standards from DPW, and ultimately pass an extensive readiness review process. When a county accepts, it can then manage the contract itself or hire an MBHO as a subcontractor for administrative services and/or downloading of the risk.

During the regional rollout, CBHNP bid in virtually every county on HealthChoices. The corporation received excellent feedback for the effort but, again, no success. People were not ready to see providers step up and manage such an immense undertaking. HealthChoices is one of the most comprehensive managed Medicaid programs in the country, and the counties (and perhaps the state) felt that contracting with CBHNP was too chancy.

However, in the fall of 2000, CBHNP found a potential willing partner. Five counties in the Capital Area of Pennsylvania surrounding Harrisburg (Cumberland, Dauphin, Lancaster, Lebanon, and Perry counties) were issuing their bid for HealthChoices. These counties had decided to accept the HealthChoices program from the state, but were looking for a partner to provide managed care services (e.g., utilization management, provider network operations, claims payment) and to assume financial risk.

The five counties, known collectively as the Capital Area Behavioral Health Collaborative (CABHC), had literally spent years in developing their model and approach to HealthChoices. Most importantly, these counties agreed that to truly join together for this undertaking, they had to do so with one voice and one set of standards.

They agreed to partner on a financial model such that the funds could be combined to effectively spread the risk. All the counties would benefit from a positive performance, and services would be available throughout the region. CABHC was created as a 501(c)3 to oversee operations and be the “voice of the counties” through its CEO, Scott Suhring, and program staff. While other counties in Pennsylvania have since developed such strategies, CABHC’s plan was extremely well thought-out and forward-thinking at the time.

The five counties were, interestingly enough, seeking a relatively short-term relationship with an MBHO, intending to develop infrastructure to replace the MBHO in time and develop a closer relationship directly with the community providers. In that CBHNP members represented a relatively large portion of the services already provided in the region and had very strong relations with the counties, the opportunity appeared ripe.

Roadblocks

CBHNP could bid on this business from an MBHO infrastructure standpoint, but was lacking two important prerequisites: a Pennsylvania license or certificate to bear financial risk and sufficient financial reserves for a program of this magnitude.

CBHNP needed a partner. The corporation approached HealthAmerica. HealthAmerica, and its affiliate HealthAssurance, cover more than 650,000 members in Pennsylvania and Ohio through HMO, point-of-service (POS), preferred-provider organization (PPO) and Medicare+Choice plans, with corporate offices located in Harrisburg. HealthAmerica has a 28-year record in the Pennsylvania managed care market, with an outstanding foundation around quality and cost-effectiveness, and comprises multiple financially stable insurance companies.

With the backing of parent company Coventry Health Care, a publicly traded managed care company (NYSE: CVH)

with more than 2 million members in 13 markets, HealthAssurance met the HealthChoices equity and solvency requirements, as well as all Department of Insurance requirements relative to risk-based capital.

CBHNP and HealthAssurance had a series of meetings and negotiations from March to August 2001, culminating in a partnership model and effectively joining with the five-county CABHC to manage HealthChoices.

HealthAssurance chose to partner with CBHNP and CABHC for several reasons. Clearly, as a health insurance company with three-year excellent accreditation from the National Committee for Quality Assurance (NCQA), the company had to see the arrangement as prudent from a financial perspective, and it could not compromise the company's commitment to quality. Further, in meetings with HealthAssurance President Fran Soistman and senior vice presidents Jan Hodges and Tim Guarneschelli, they developed an appreciation for the commitment of both CBHNP and CABHC to the importance of this program to the community, and, as a long-term member of that same community, understood that through their assistance there could be true innovation in healthcare for those members in need.

The partnership

CBHNP, CABHC and HealthAssurance developed a unique contracting and partnership relationship. HealthAssurance, as the license holder, would contract with the five counties, who would be represented by CABHC as the oversight contract entity. HealthAssurance, in turn, contracted with CBHNP to manage operations and assume direct risk, with the contracting and dollar flow depicted in the chart on last page (HealthAssurance is abbreviated as HASPA in the chart on last page).

To complete the deal, CBHNP had to arrange for the direct risk contingencies, which amounted to raising a *several million dollar* cushion against losses on the medical risk. To do so, they had to quickly accumulate cash and obtain both letters of credit and a performance bond — all backed by community providers throughout Pennsylvania. And all of this had to be put in place within months. Program start-up was looming ever closer.

CBHNP met with dozens of banks and lending institutions (even venture capital companies), as well as insurers and bond agents. Most of these organizations were not willing to assist without matching cash balances. For example, to receive a $2 million bond or letter of credit, CBHNP (or its member providers) would have to post $2 million in the bank. This was not possible dollar for dollar for the amount required, and other solutions needed to be found.

At the same time, CBHNP needed to meet with member providers to assist directors and their boards in understanding what they were, in fact, backing. For example, when the performance bond was eventually obtained, it had to be backed partially with cash (built through the contract) and with provider guarantees — joint and several. In other words, an individual agency would need to take entire risk on the bond, even if CBHNP did have backup side agreements spreading the risk over several providers.

Another significant undertaking was to quickly and effectively build the MIS infrastructure for claims payment, internal management reporting, and external reporting and data export to CABHC. Most information systems that had a history with HealthChoices were proprietary, and while many vendors offered to build a system, the time was just not available and the potential cost prohibitive. CBHNP needed a comprehensive system at a reasonable price, virtually immediately.

CBHNP approached InfoMC Inc. about its eCura® system. Several corporate staff were familiar with the system and the company's principals. InfoMC proved a willing partner and implemented a solution in a rapid, high-quality and cost-effective manner. This MIS operation also allowed for further collaboration among CBHNP and CABHC along with their MIS subcontractor, Allan Collautt and Associates.

Together, all four organizations were able to build an efficient MIS that allowed for the successful completion of the MIS portion of the state's readiness review process prior to implementation. Just as important, the MIS model afforded another example of how the parties share information and data and have true joint ownership of that data. This collaborative MIS model was unique to Pennsylvania and HealthChoices among counties and MBHO subcontractors.

With financial risk secured and a MIS in place, program operations were ready to begin. The partners agreed on a basic division of responsibilities (see last page).

Since CBHNP members represented only a portion of the overall provider network in the Capital Area, it had to assure the counties (and via the counties, the state) that it would accept all current Medical Assistance providers through an open network contracting process. A further HealthChoices standard was that members must be offered provider choice for all services. CBHNP held meetings with community providers (including non-CBHNP members) *before* the bid to CABHC so that the community at large would be well-aware of CBHNP's intent to include these providers. In fact, several non-CBHNP members offered letters of support to CABHC on behalf of CBHNP.

It was also understood that CBHNP would be held to a somewhat higher standard than other MBHOs. CBHNP was under a microscope: Would it really be able to build such significant MBHO infrastructure (including the eCura system) in such a short time? As a provider-based MBHO, would it really be able to effectively manage care? Would all providers really be treated fairly — even non-CBHNP providers? Would finances hold?

Achieving success

The Capital Area HealthChoices program is now well into its second year. The program has been an operational and finan-

cial success. Reserves have been built, the needed risk contingencies have diminished (e.g., elimination of the performance bond), and most importantly, consumers, families and persons in recovery are receiving the services they need.

CBHNP has held to its model of limiting administrative expenses, maximizing dollars available for care. Innovative models (such as for children's services) are being developed and meaningful stakeholder involvement is occurring. CBHNP met 100 percent of its first-year performance standards with CABHC, focused largely on claims payment and reporting via the eCura system.

Lessons learned

In looking back, there are several lessons learned.

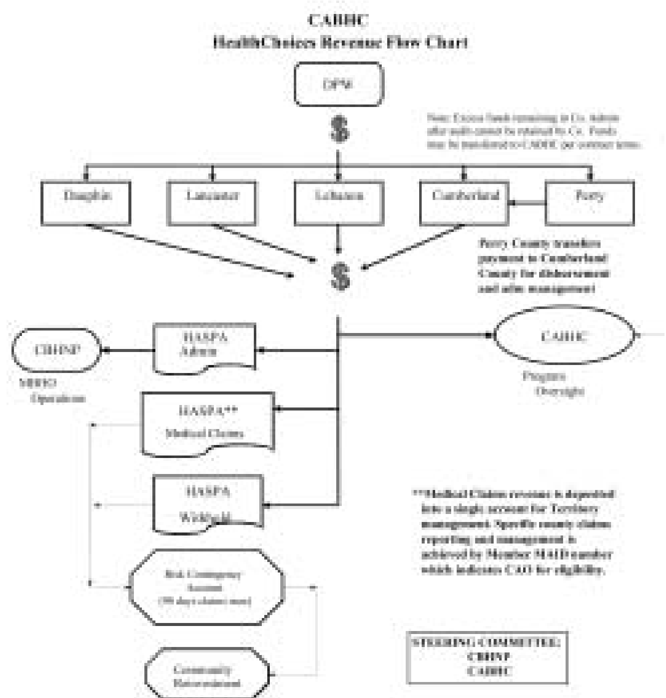
Lesson One: It takes commitment. The CBHNP provider membership stuck with the network concept for years — without revenue — because of belief in the model. Members continued to pay dues (now eliminated) years beyond what many would have believed a reasonable investment. Building a provider-based MBHO takes time — and much of that time is in waiting until the payer and stakeholder community is ready.

The providers also had a clear understanding of what they were trying to accomplish. No member provider joined CBHNP thinking it would now make endless profit and significantly raise its revenue stream; rather, it joined to create true system change and be a driver in managed care programs that greatly affect those in need within the community.

Lesson Two: Be creative and persistent. Finding the right licensed partner, willing banks, bond companies, and so forth was an immense task, taking months of around-the-clock telephone calls and meetings. The providers, too, had to back the project — significantly so at program inception. It comes back to commitment and belief that it was too important to fail.

Lesson Three (the most important): Have the right partners. CBHNP, CABHC and HealthAssurance have joined together in a unique relationship. While the boundaries of roles and responsibilities are clear, and it is always understood that CAHBC ultimately holds the contract with the state, the day-to-day relationship operationally works in a different manner. The program operates within an "open book" structure where all parties have the same information and work together in a collaborative manner toward success. The three organizations are true partners and goals are aligned. On an informal basis the parties have unlimited contact; on a formal basis the three partners come together monthly through a steering committee to review all aspects of the program.

CBHNP could not run MBHO operations effectively without the expertise from CABHC and the counties. The counties, along with the community providers, have a long-term commitment to the consumers and families and understand the needs and gaps in services. HealthAssurance, in turn, has brought its insurer expertise in terms of fiscal models and oversight, as well as the delegation (and subsequent audits) of such areas as utilization management, quality improvement and credentialing. Together the three organizations, while different in many ways, support the effort of the whole.



DIVISION OF RESPONSIBILITIES

	HealthAssurance	CBHNP	CABHC	Capital Area Counties	Stakeholders
Contract with DPW				x	
Contract with Counties	X		X		
License	X				
Equity Risk-Based Capital	X				
MBHO Operations		x			
Risk	x (delegated to CBHNP)	x		X (delegated to HASPA)	
Risk Contingencies (e.g., cash, LOCs, bond)		x			
Service Delivery/ Clinical Models		x	x	x	x
Joint Operating "Steering" Committee	x	x	x		
MIS: Internal		x			
MIS: External			x		
Committee (e.g., UM, QI) Involvement		x	x	x	x
Program Oversight	x		x		

Looking ahead

Like other states, Pennsylvania now faces budget cuts in Medicaid and human services and there will no doubt be difficult times ahead. As for HealthChoices, there will always be some continued disbelief of a provider-based model, and the concept of payers holding a higher standard for CBHNP in comparison to more traditional MBHOs is perhaps inevitable.

But this is what CBHNP and the community providers understood when they stepped up in 1994. As requirements change — be it by program change or economic condition — CBHNP and its strategic partners will make needed adjustments to achieve the basic vision: getting dollars to care and services to people in an innovative, high-quality manner.

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