FREQUENTLY ASKED QUESTIONS ABOUT BEHAVIORAL HEALTHCARE NETWORKS

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Thomas Lucking is a behavioral health consultant who has provided services in more than thirty states. He has facilitated the development of networks and reviewed the functioning of networks in many of these states. The questions that follow have been posed to him by those interested in behavioral healthcare networks.

What do the terms "network," "systems of care," "managing entities," and "administrative service organization" mean?

Network

The term "network" may refer to a panel of contracted providers, whether or not the providers have any relationship with each other besides the contract with a common purchaser. "Network" can also refer to a provider combination designed to add value, such as service enhancements, cost efficiencies, and expanded administrative capacities.

System of care

The term "system of care" refers to an organization of services across levels of care, provider organizations, and service categories formed to better meet the multiple needs of service recipients. A behavioral health network may be part of a larger system of care.

Administrative service organizations (ASO

An ASO is an entity that provides administrative services. Sometimes ASOs are formed as provider partnerships. An ASO might be a managed care organization, a specialized entity hired by the purchaser, an entity managed by network partners, or an entity in partnership with provider organizations. The terms "ASO" and "managing entity" are sometimes used interchangeably.

Managing entities

A managing entity refers to an entity hired to provide certain network services. Although sometimes used synonymously with the term ASO, most often "managing entity" means the entity that focuses its efforts on contracting, network development, and care management. Like an ASO, a managing entity might be a managed care organization, a specialized entity hired by the purchaser, an entity managed by network partners, or an entity in partnership with provider organizations.

Why is network development so important today?

Many of today's service and financial challenges require solutions that are beyond the scope of single agencies. Networks are often the preferred vehicles for community-based systems of care, continuums for people with co-occurring disorders, special contracting carve-outs, and the development of otherwise unattainable administrative

efficiencies and capacities. In particular, the development of networks facilitates the transition from services delivered in isolation to services delivered in person-centered systems of care. Managed care contracting was once the primary force driving network development, and it remains important. However, the transition of community systems from "silo services" to "systems services" now exerts as much or more force motivating network formation.

Are behavioral health networks best developed by providers or purchasers?

Networks can be formed by purchasers, entities hired by purchasers, or providers. The organizers of provider-sponsored networks must remember that purchaser enthusiasm is an essential ingredient to network success. The network loses when purchasers experience provider networks as a competitor for functions or a barrier to the purchaser's goals.

What determines network design and structure?

Networks forms should follow network functions. This principle holds true for both the design of the network's service delivery infrastructures and structures for governance.

What are some common behavioral healthcare network functions?

Networks are organized to provide functions or added value features that are outside the scope of any one organization. Examples of network functions are:

- Designing and providing integrated care across levels of care, organizations, and service systems. Such networks may form the core of a system of care.

- Developing and delivering evidenced based practices. The network may do so by developing services, providing training, and developing peer information exchanges and reviews.

- Developing the capacity for offering contracting options, such as a single contract for the network, full or partial risk contracts, case rates, and volume-discount contracts.

- Serving as an administrative services organization (ASO) for billing, information management, human resource management, or other services.

- Reporting and quality-management efforts.

- Providing utilization management (prospective, retrospective, concurrent, or some combination).

- Marketing

What are some common network structures?

A managing entity or ASO may be hired by a purchaser to form and manage a network or to provide certain services on behalf of the purchaser. In this case, the managing entity or ASO has a contractual relationship with the purchaser. The managing entity or ASO may also act as the contracting entity for the network, in which case the ASO contracts with the provider organizations.

The purchaser may hire a provider-sponsored network to provide both managing entity and network direct service provision. In addition, the network providers may choose to use the managing entity as a vehicle for ASO services, such as billing, training, or human resources. In most cases, the network partners will have to contract with providers who are not partners in order to meet purchaser requirements for service and geographic coverage and consumer choice.

The structures grow in geometric complexity when the designated regional purchasers, such as the community mental health boards in some states, form regional partnerships and also provide services. At times, the regional partnership is a sort of purchasing network that buys services from itself as a provider network as well as other providers as needed.

There are many more possibilities. Variety is the rule. In addition, the managing entity is likely to hire an additional layer of networks for subs-specialties, such as substance abuse, children's mental health services, adult mental health services, and services for those with developmental disabilities. These sub-networks may also have sub-networks.

Aren't the added layers of network management inefficient?

They can be. Planners need to guard against duplicating management and administrative activities and costs. Yet designing and delivering community-based, person-centered care requires much intensive work. Provider networks are positioned to integrate and coordinate care at the service level. Community-based, coordinated is more valued – and often more expensive – than other options for persons with multiple service needs. Planners need to allow for the costs of network development and management.

Why do provider networks seem to take so long to develop?

Developing network infrastructures is labor intensive. For example, community-based clinical pathways develop pathway-by-pathway and often person-by-person. Also, networks are often the new venues for mission-critical political and financial relationships. Successful providers are understandably cautious about delegating mission critical functions to new entities that often include their competitors as managing partners. Consequently, most successful provider-sponsored networks develop gradually

as partners and purchasers develop confidence in the networks and become willing to add more functions.

Can't proprietary managed care organization (MCOs) quickly develop networks without all of the time suggested above?

Proprietary MCOs are able to develop a certain kind of behavioral health networks quickly. They have care management, information, and reporting systems on hand and ready to deploy. Many MCOs are most adept at establishing and managing networks designed to reduce utilization and costs among already developed service lines. For example, primarily by using MCOs, private insurance plans succeeded at reducing private insurance payments for substance-abuse treatment fourfold from 1992 through 2001. Reductions in lengths of stay and admissions occurred at all levels, including low-intensity outpatient care. [1]

The kinds of networks that support community-based systems of care cannot be developed rapidly by any type of entity. There is no short cut past the labor intensive process of community-specific, service pathway development. Also, most community-based, nonprofit organizations are much better positioned than MCOs from outside their communities to design, develop, manage, and deliver effective community-based care. Most have long term relationships with other local service systems and funding bodies. Systems of care can be built on these relationships. For example, it is difficult to imagine service clubs, child-welfare agencies, United Ways, or school systems collaborating with proprietary MCOs on community projects. Such collaborations are frequent with community-based organizations.

Does it follow that networks managed by community-based organizations are better vehicles for public systems than are proprietary MCOs?

Community-based organizations have the community ties that better position them to develop systems of care. However, they forfeit this better position if they use networks as vehicles to preserve their historical service offerings. Also, some proprietary MCOs have capacities that can be necessary in some situations. These capacities include information systems, utilization management systems, and sufficient reserves to meet the thresholds for accepting insurance risk. As a result, some community-based providers enter partnerships with proprietary MCOs to draw in their capacities.

How do financially stretched local systems obtain the resources to develop networks?

Provider organization "sweat equity" can start a network, but it is rarely sufficient for network success. Private or public grants or direct funding from public purchasers are almost always needed. At times, providers attempt to fund the expense of network management from a portion of the service fees that flow through the network. However,

[1] T. Mark and R. Coffey, The decline in the receipt of substance abuse treatment by the privately insured, 1992-2001, *Health Affairs,* Volume 23, Number 6, November/December 2004: 157-162

if these fees are already heavily discounted before the network takes its service fee, then both the network and providers are left with inadequate support. The purchaser's willingness to fund most or all of network development and management costs is obviously favorable. Likewise, the purchaser's unwillingness to fund network formation and management costs may reflect lukewarm support that would doom the network in any case.

What are some general principles for provider organizations to follow in developing networks?

- Avoid the temptation to start with the design of the network's partnership or governance structure. This should come later. Instead, begin by identifying the ways that a network might better meet the needs of specific service recipients and a specific purchaser. Specificity keeps the network real.

- Obtain sufficient legal council early to identify and address any possible anti-trust and Medicaid fraud and abuse issues.

- Develop the network in dialogue with the purchaser, and follow the purchaser's lead when deciding about services and organizations.

- Obtain resources for network development and management. The unwillingness of the purchaser or stakeholders to support network development and management may signal a lack of support that would be fatal in any case.

- When it fits the network's mission, get underway early with service coordination improvement activities. In most cases, the willingness of partners to use the network for mission-critical service delivery and contracting will await their experience of success with the network with activities less immediately tied to financial success. Improving service coordination has its own value, and can be a starting point for developing the experience of successful transactions. It can be started at the level of direct staff members, without a formal network partnership in place.

- Identify and discuss the layers of complex political and financial relationships that need to be mediated through the network. Openly discuss the service and organizational interests of member organizations. These discussions are best undertaken in the spirit of careful listening and mutual support. Staking out firm positions, especially early on, invites opposition and stalling tactics.

- Be willing to start small and accept incremental success. Also be prepared to abandon networks that lack forward momentum. Network partners often feel obligated to slog on, wasting scarce resources, out of loyalty to partners. The clearest sign that network development efforts will not bear fruit is lack of support by the purchaser.

What are the complex relationships that may need to be considered when developing networks?

Depending on the type of network, several relationships need especially close attention.

- The relationships of provider organizations to other provider organizations as network partners. These relationships become more complicated when these organizations are competitors within the network.

- The relationships between network as an entity to the provider organizations as network providers. These relationships becomes more complicated when some of the network provider organizations are also the network's managing partners.

- The relationships between network staff members to some or all provider organizations as network governors and network providers. For example, from time to time, staff members may find themselves trying to address problems of poor performance with provider organizations who are also the staff member's managing partners.

- The relationships between the purchasers to individual staff members as well as the purchaser to the network as an entity.

For provider-sponsored organizations, what method of network governance best supports network development and stability?

As if to keep network management interesting beyond the formative stages, it turns out that the method of network governance often needed at inception of networks is different than the governance method that best sustains high-functioning networks. In many cases, initial network formation is best supported by a "one-organization, one-vote" governance model, with governing organizations being the ones most important to the purchaser and stakeholders. At the time of initial formation, smaller, less influential organizations tend to be threatened by larger, more influential organizations. These smaller organizations are most assured by a governance structure that tempers the influence of larger organizations by "one-organization, one-vote" governance. However, as networks develop and add functions, the disproportionate financial, political, and market contributions made by different organizations take center stage. At this stage, networks risk losing essential partners unless they modify their governance methods to recognize the larger contributions of some organizations.

Fortunately, by the time a network develops to the point of needing to modify its "one-organization, one-vote" governance structure, network partners have had a sufficient number of successful transactions to develop trust. Smaller organizations feel secure in allowing larger organizations to have governance representation in proportion to their contributions to the network. This differential governance representation may

take the form of levels of membership and governance, some sort of weighted voting in proportion to investment, or shares in proportion to investments.