

Course 3A

Lesson Three

Contracting and Risk Sharing With Providers!



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Risk Issues Affect Providers, Too!



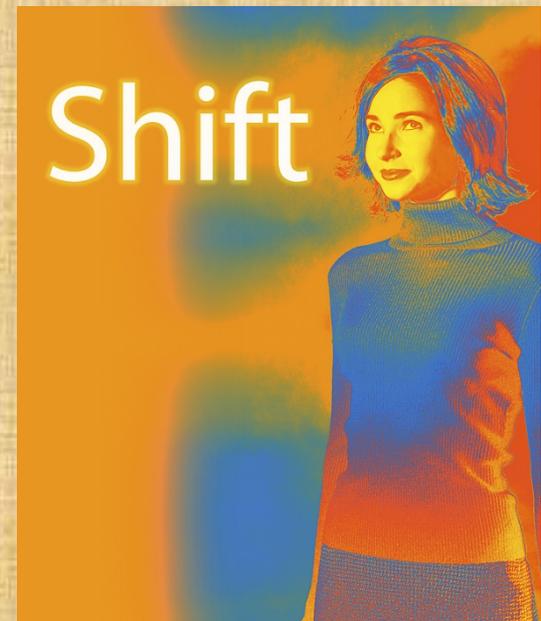
It should be clear by now that **'CONTROL OF THE HMO'S RISK' = 'CONTROL OF THE COST'** associated with providing Medically Necessary Services for all of the plan's enrollees. And without a doubt, the *strategic methods* that the managed care company uses to control its risk have a significant impact upon providers.

And the impact upon providers is **NOT** related simply to money. There is a significant amount of impact upon their **CLINICAL AND PROGRAM** practices as well!

In order to make the money **stretch** for the life of the contract, the at-risk entity (an HMO or other insurance company) **CONTAINS OR LIMITS** its risk through *various approaches* which will impact

Affects
Providers . . .

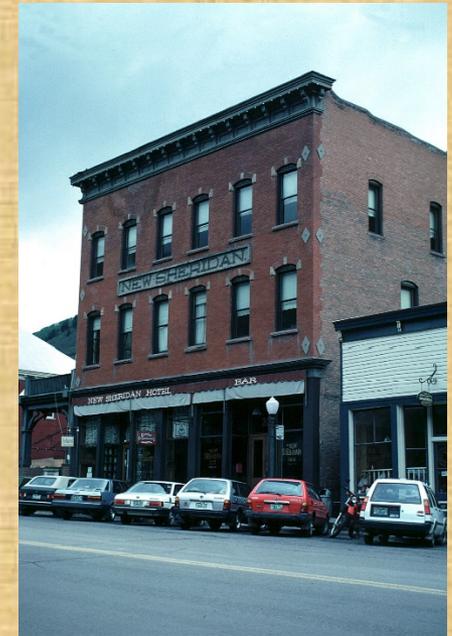
- **HOW** the money is spent (which *services* will be provided) . . . and
- **WITH WHOM** the money is spent (which *providers* will provide the services).



**This shift impacts providers –
but it's NOT all BAD!**

Q: Is this course and this module actually relevant for those of us who are in private practice or private organizations?

A: YES. In most states, Managed Care [in which authorization for treatment is governed by some type of 'Care Management' pre-approval or treatment authorization process] is coming on strong, due to the shrinking funds available to behavioral and rehabilitative health. This movement affects both the traditional public sector providers and the private sector providers.



And why is this?

It is important to know that the very same principles that guide managed care companies (MCOs) in the treatment approval process ALSO now guide commercial insurance carriers such as Aetna, Blue Cross Blue Shield, and others . . . when it comes to approving or disapproving your requests for behavioral health treatment for your clients and patients.

If you are on a commercial insurance ‘provider panel’, you will find that – as the demand to reduce healthcare costs increases – the vigorous use of ‘pre-approval’ and ‘continued stay’ criteria will also increase.

And so yes, this course applies to individuals working in the private sector as much as it applies to those working in the local MHMR Center or Substance Abuse Treatment Center.

A bit of history about how private practitioners and organizations became involved in this managed care movement . . .

- **HMOs, MCOs, commercial insurance carriers (like Blue Cross Blue Shield, Aetna, and others who include behavioral health and rehabilitative treatment in their benefits schedule) -- and even State-managed Medicaid Plans -- now utilize the services of the private sector as much (and oftentimes more) than they utilize the local MHMR Centers and other State agencies. This may not be true in your state at this point in time - but that's the direction that most States are moving.**

- **The reason for this is that many PRIVATE SECTOR providers were initially less set in their ways than providers in the 'traditional' government-funded Community Service Programs. They were willing to do some things differently under this new approach to health care.**

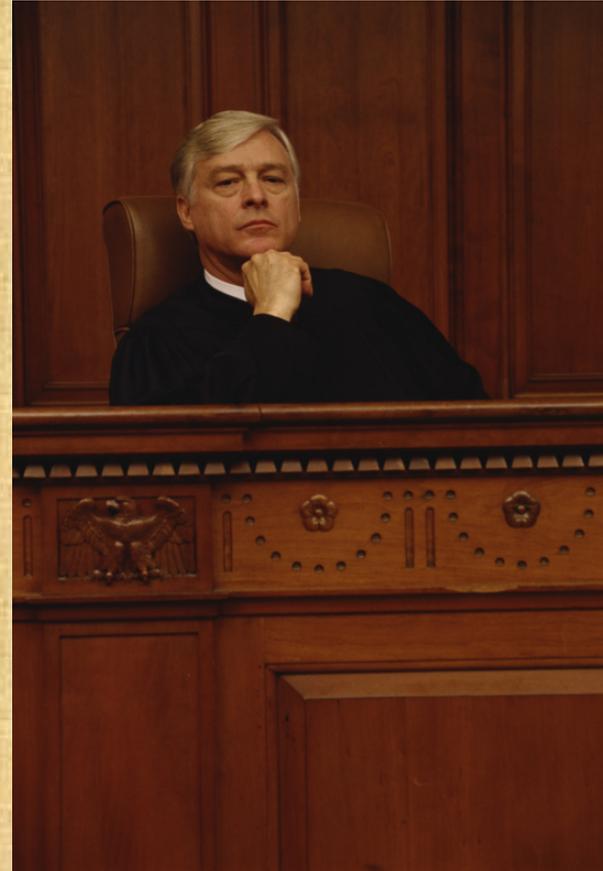


- **At least during the first months of a new managed care "roll out", these private sector providers also tended to be more creative and flexible in striking cost effective contracts to deliver 'innovative services.'**

- **Furthermore, in most states, traditional Medicaid providers had become accustomed to automatic annual contracts . . . whereas private sector providers are used to working for every penny they get (a.k.a. Fee For Service)**
- **And thus the private sector was perceived as easier to work with (according to most HMOs, MCOs, and other Care Management-oriented insurance companies).**
- **Granted, there were and are some private practice trade organizations that continue to fight Managed Behavioral Health Care - but the number of such instances is waning.**

- **NOTE: The private sector DID NOT AUTOMATICALLY grab a bulk of the business *in every state*. Why not? When Medicaid funding went into a managed care mode across the country, the 'TRADITIONAL PROVIDERS' within the community (usually publically funded agencies) made an effort to ensure that they would be the ONLY organizations to get these new managed care contracts. AND some States supported the Traditional Providers in this bid for exclusivity and claims of 'imminent domain' – at least initially.**

- **But the Federal Government eventually said NO to such bias in favor of the Traditional Providers - opening the gate to enterprising private provider organizations and private practices to grab a share of the business.**



And now there are partnerships!

Most progressive public sector providers have now entered into the movement with gusto, to ensure their survival. Many of them now partner extensively with the private sector, to deliver cost-effective treatment with good outcomes – much to the delight of the managed care companies (whose main concern is that those services are delivered – one way or another).



If the Affordable Care Act (ACA) insurance plans have not seen much activity in your state yet, they likely will. Some states are just now moving into Managed Care, and thus the ACA will be quite an introduction! Some understanding of how Managed Care works - and of the opportunities that are available to the private sector through interesting contracts – can be helpful to private practitioners and private organizations, especially in states that where Managed Care has not been a big ‘item’ yet, in terms of a shift in how treatment and rehabilitation is delivered.

**But even without the
ACA or Medicaid
Managed Care . . .**

**. . . as the pressure on the
commercial insurance
companies increases – to
REDUCE PREMIUMS AND THE
COST OF HEALTH CARE – we are
going to see an increase in the
pressure placed on ALL
providers to use effective and
innovative services, sometimes
at reduced rates, but in
increased volume.**



Risk Affects Providers . . .

Yes, the approaches which virtually ALL insurance companies employ to contain (or limit) their risk – including the use of intensive Care Management – have *tremendous implications* for providers – and it's NOT all BAD! There are opportunities for those with an enterprising and creative spirit, to deliver treatment in new ways.



CARE

MANAGEMENT:

“How sick IS this patient – and does he REALLY need the treatment you want to provide?”



Risk Affects Providers . . .



For example, if there are too many inpatient or detox days utilized, and there are not enough Intensive Outpatient (IOP) slots which could reduce the need for inpatient or detox, this clearly requires a 'fix' – so, the HMO will want to **EXPAND** the IOP slots within the network. **OR,** if consumers with serious mental illness are deteriorating after an inpatient stay, the managed care company will want to contract with providers who can deliver **INTENSIVE** community based programs designed to keep people out of the hospital – such as Assertive Community Treatment (ACT) Teams and intensive home-based treatment programs.

Risk Affects Providers . . .



Basically, they contract with providers to bring in some NEW PROGRAMS and treatment options which may not have been available or accessible before . . . so that the right services can be delivered in the right amount, at the right level of intensity, and for the right amount of time. Always wanted to operate an IOP? Now you have a reason, and funding to do it with!

Risk Affects Providers . . .

- **Are you new to the provider scene? This may be your chance! In order to control their RISK, HMOs expand the network of providers beyond those who have traditionally provided the services for the target population. They ADD new providers who have demonstrated that they are competent, creative, and are willing to CLOSE THE GAPS that may be present in the delivery system.**



Risk Affects Providers . . .



Looking for quality!

- **Do you care whether the services are actually EFFECTIVE? HMOs ensure that money is spent only on services known to be effective, so that there is 'more bang for the buck' in terms of good outcomes and the use of their limited funds. Working this way reduces their RISK. Consequently, community programs which have demonstrated that they have good program outcomes are important to HMOs.**

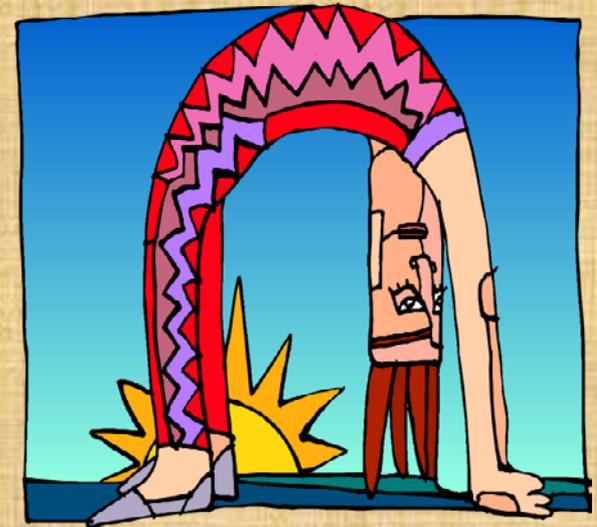
Risk Affects Providers . . .

- **If your practice or organization has worked hard to ensure good outcomes, and if you express an interest in working with the HMO to measure and track the treatment outcomes of consumers in your care, the 'at risk' entity (the HMO or other such contractor) will sit up and take notice.**



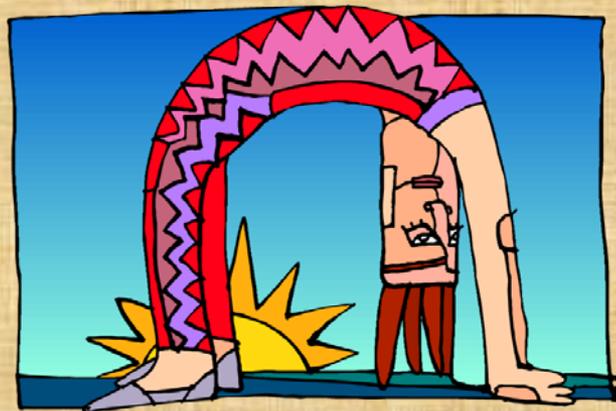
Risk Affects Providers . . .

- **Are you the FLEXIBLE type – willing to look at NEW ways of delivering and documenting treatment? This is important because HMOs make decisions [‘Utilization Management’] about how much treatment is required of a certain type before moving the individual on to another treatment modality – which may contradict how treatment has always been provided.**



- **The HMO's decisions may even contradict a provider's prevailing clinical beliefs about 'how much' of 'what' is needed at any given point in time. For example, the managed care company will probably limit how long an individual remains at the more expensive levels of care – they may 'step them down' to a lower (less intensive and less expensive) level of care long before the provider (in the past) would have done so. Disagreements abound!**





Of course, it is up to the State or contracting authority to control misuse of the 'treatment limitation' process, so that clearly inappropriate limitation of services does not occur. But being **FLEXIBLE** in looking at ways to do things is **VERY IMPORTANT** if you are a provider.

And if these flexible provider characteristics seem to describe you or your agency, then you may be a candidate to **TAKE ON SOME LIMITED RISK!**

Risk Sharing With Providers – Another Contract Example – CAN be ‘The Good’!

HMOs may want to ‘share the risk’ with certain providers – called ‘Limited Risk Sharing’ or ‘Shared Risk’. This is often a good option when it is available! Most of these approaches are very workable, and these options . . .

- depart from ‘sure thing’ block grants and fixed State contracts, but do it *constructively, and*
- encourage creativity, efficiency, and ownership of the managed care rollout by providers. They learn to ‘managed the care’ of their consumers, too!



**The Good?
Oftentimes,
YES.**

Provider risk examples

- ***Case Rates*** A CASE RATE is a 'limited risk' or 'shared risk' payment arrangement which may be available to providers depending upon the source of funds in the managed care plan. In this fee arrangement, the provider agrees to accept a *flat rate fee* for each pre-approved enrollee, intended to cover an array or specified 'package' of services which the client may require during a set period of time [such a month or six months].



Case Rates

- **In this contract option, the provider is given more control over the individual plan of care and the determination of which services will be provided to individual clients, and for how long. You do not have to ask the HMO for 'permission' at each step of the client's treatment process, with a case rate, once the arrangement has been approved for a period of time – from a month or even longer.**



Depending upon the nature of the client and his history, some case rates may be approved for 3-6 months.

Provider risk . . .

This sort of agreement is indeed risk, but without hanging over the edge.

Under a Case Rate arrangement, the provider is 'risking' or 'wagering' that the outpatient services which he must provide to the *majority* of the clients will be 'LESS INTENSIVE' rather than 'MORE INTENSIVE', i.e. that most clients will NOT require intensive services. If that is so, then the total pot of Case Rate dollars will **stretch** to cover the intensive services required by the *minority* of the clients. And hopefully there will be some money left over!



Provider risk . . .

To make a Case Rate work, the provider must ensure that crisis intervention *and support services* are available for ALL of the CASE RATE clients, so that MOST of your clients will NOT require a lot of high-end intensive services [or, will not relapse following the delivery of high-end services]. What's 'high end'? These are the most costly outpatient services such as Intensive Outpatient (IOP) and Day Treatment.



What is the CD or MH provider doing here? He is carefully 'managing' the care received by his Case Rate clients, so that his money will stretch - just like a mini-BHO.

Provider risk . . .



- **The services which the provider must be able to deliver are spelled out in the contract. This is a kind of risk that may be worth taking, if you know your population well. Such case rates may apply to clients in specified categories, e.g., SMI adults, SED children, SA/CD clients, juvenile justice adolescents, children placed in foster care.**

Provider risk . . .

- **Case Rates have also worked well with children in CPS custody, in some locations, and works well for monitoring and behavioral health mentoring of juvenile justice probationers in various programs across the country.**



Provider risk . . .



Assertive Community

Treatment (ACT) – another example of a mental health Case Rate: Rather than paying fee-for-service for each treatment visit that Severely Mentally Ill (SMI) adults or Seriously Emotionally Disturbed (SED) children require, the HMO, BHO, MCO or other Administrator pays a *flat fee for one full month of 'wrap around' services* delivered in the community, on a per-client basis.



Provider risk . . .

- **SED and SMI clients generally do well with this sort of flat rate 'wrap around' arrangement [which typically does not require the provider to pay for inpatient and residential care]. These clients are assigned to an Assertive Community Treatment (ACT) Team of individuals (typically including a nurse and psychiatrist's services), which provides 24/7 crisis and rehab support to the client in his home and in the community.**





Provider risk . . .

- **PRE-PAYMENT** *for a limited set of front-end intake and initial services.* An example is this:

A CD provider consortium or a CMHC accepts a set monthly 'pre-payment' to perform a limited package of 'front end' MH or CD services. They are paid \$1.00 for each member of the ENTIRE ENROLLED population, per month, to do telephonic intake, the front-end CD or psychiatric assessment, the initial 4 sessions, and brief outpatient crisis stabilization counseling.  They provide these services ONLY for those *who actually seek MH or CD services, which is a small percentage of the enrolled population.*

Provider risk . . .

So for an enrolled population of 10,000 individuals, maybe 6% of the enrolled population (or 600 people total) will actually seek services each year. This means that to perform these services for approximately 600 people, the CMHC or CD Provider Consortium receives \$10,000 per month or \$120,000 per year.



QUESTION TO ASK YOURSELF:

Would the reimbursement cover your costs? There is some risk here, but not overwhelming.





Provider risk . . .

- *Or, another type of **PRE-PAYMENT** for a specified set of services – THE FLAT RATE CONTRACT. Example: A provider organization accepts a flat monthly fee of \$65,000, to deliver a specified package of MH outpatient services to a specified number of SED or SMI individuals (say, 175-200 persons). And the provider is expected to deliver a targeted **AMOUNT** of services to those 175-200 persons, at a specified level of intensity – say an average of two face-to-face contacts per week out in the community, with*



A set monthly pre-payment for a limited set of services.

Provider risk . . .

**contacts averaging 45-60 minutes. So . . .
if you are paid that flat rate of \$65,000
dollars per month to deliver those services,
would the monthly reimbursement cover
the average cost of providing the services
to your targeted number of 175-200
clients? You would have to negotiate a
fee that would cover your costs. There is
some risk here, but not overwhelming.**



Provider risk . . .



- ***Sub-capitation of a provider.*** Example: As we discussed a few slides back, an HMO may 'sub-capitate' a large provider organization, such as a Community Mental Health Center Consortium or a Hospital District or other provider group such as a CD Provider Network – contracting with the provider to accept full or partial risk for the management and delivery of the care for the *entire covered population*. The HMO has thus effectively '*off loaded*' its risk onto the provider organization. [Refer to the discussion about Sub-Capitation and Serial Sub-Capitation in the previous lessons.] *CEU By Net!* does NOT recommend this option to providers!

Provider risk . . .

Accepting a true sub-capitation (where all or most of the risk is passed down to the provider) is indeed a huge risk for the CMHC or CD Network or other provider entity – a very great risk, especially if there was not enough money to serve everyone who came to the door, before managed care.



***Remember,* under true capitation or sub-capitation, the ultimate risk-holder must treat every enrolled and eligible individual who comes to the door. You cannot pick and choose. And waiting lists are not allowed!**

Provider risk . . .



- ***Preferred Provider status.*** Often an excellent contract option, with limited risk. This option may involve agreeing to accept lower fees for traditional routine services than are paid to the typical 'provider on the street', in exchange for 'preferred provider' status and **HIGHER** fees for **SPECIALIZED** services. There will likely be additional responsibilities in the provider network, but ultimately more revenue. May also involve an opportunity to play a key roll such as the 'Front Door' for all clients of a certain category

Provider risk . . .

(e.g., SMI or SED clients, juvenile justice clients, child welfare children, or SA/CD clients).

As a 'preferred provider', you will likely be required to accept more high-risk consumers for treatment than non-specialized providers accept – such as SMI or SED or substance abusing clients with a long history of relapse. This is why we say that this is a 'limited risk' or 'shared risk' arrangement. You may also be required to deliver better outcomes than the typical private provider, in exchange for 'preferred provider' status. This, too, is a 'limited risk' of sorts. But it is a 'risk' worth taking, in our opinion.



Provider risk . . .

- ***Fee For Service.*** Actually, simply moving to fee-for-service [instead of continuing to receive an annual fixed \$\$ contract from the State or the Feds of local entities] is somewhat risky, in that you earn money *only* for each unit of service actually delivered. There is no 'regular monthly check'. And waiting lists are not allowed. Word to the wise: Those who have diversified (expanded) their funding streams beyond the managed care contracts do better here. Having all your eggs in one basket is not wise!



In the following lesson (your last for this course) we'll dig deeper into the clinical side of Care Management and how providers can cope with it from a practical, clinical perspective.

Congratulations!



You have completed Lesson 3 of Course 3A. You may complete the short quiz for this lesson either now or later. To reach the quiz link, return to [My Home Page](#) and click on Quiz 3, Course 3A.

You can take each quiz as many times as you want, until you pass it. There is no penalty for failing a quiz, and you may retake it immediately.

So either take the quiz now, or you may resume the course – your choice! To move on to the 4th and last lesson of Course 3A, return to [My Home Page](#) and click on Lesson 4, Course 3A.