

## Course 4A

### Lesson Two of Module 201

# An MCO, Doing Some 'Risk Sharing' With Its Providers? How's That?

**Hint: It Involves Managing  
Some of Your Own Clients' Care!**





# 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 for example) **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 impacts providers – and it's **NOT**  
**all BAD!**



# Risk Affects Providers . . .



Yes, the approaches which managed care companies employ to contain (or limit) their risk have *tremendous implications* for providers – particularly those with an enterprising spirit – and it's NOT all BAD!





## Yes, the HMO's Risk Affects Providers . . . And it's NOT all bad!



**For example,** to minimize their risk, HMOs can 'move the money around'. 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.

## How the MCO's Risk Affects Providers . . .



**Basically, managed care companies control their RISK of losing money by contracting with providers to bring in some NEW PROGRAMS and treatment options which may not have been available or accessible before. Through this approach, 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 may have a reason, and perhaps the funding to do it with – through a special MCO contract!**

## Risk Affects Providers . . .

Are you interested in doing something new with an MCO? This may be your chance! In order to **CONTROL** their **RISK**, MCOs **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.



They are also **LOOKING FOR** providers who are willing to cooperate with the **CARE MANAGEMENT** process (which is the emphasis of the Module 301 of this course). And they're looking for those who are **QUALITY-oriented**.



## Risk Affects Providers . . .



***Looking for quality!***

And speaking of Quality . . . do you care whether the services are actually **EFFECTIVE?** HMOs ensure that money is spent only on services known to be effective – that's part of **CARE MANAGEMENT** – 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.



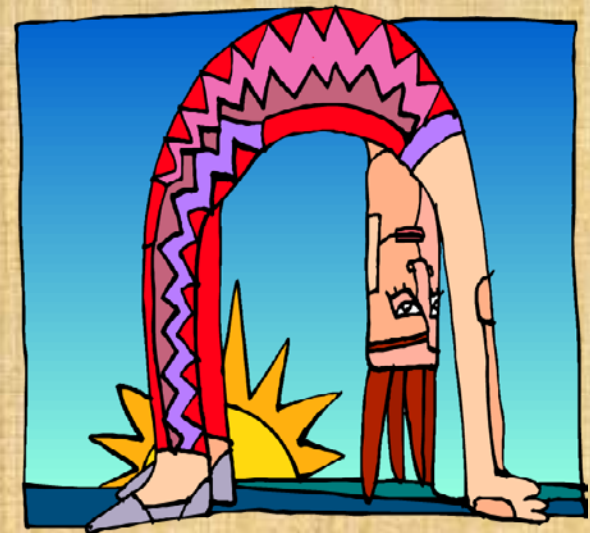
## Risk Affects Providers . . .

- **If you or your organization have 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.**



- **Are you the FLEXIBLE type – willing to look at NEW ways of delivering and documenting treatment? This is important because HMOs make those CARE MANAGEMENT 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.**

## **Risk Affects Providers . . .**



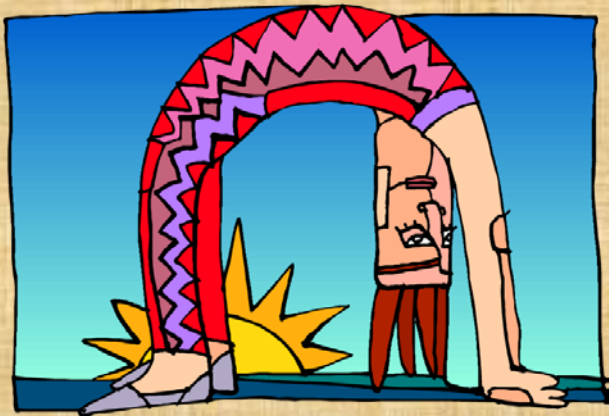
- **The HMO's Care Management decisions may even contradict a provider's prevailing clinical beliefs about 'how much' of 'what' is needed at any given point in time. For example, the managed care company will probably limit how long an individual remains at the more expensive levels of care – they may '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.**

## **Risk Affects Providers . . .**





## Risk Affects Providers . . .



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 non-traditional ways to deliver treatment is **VERY IMPORTANT** if you are a provider.

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

# 'Limited Risk Sharing' – WHAT are we talking about? And can it really be 'The Good'? Yes indeed!

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 . . .

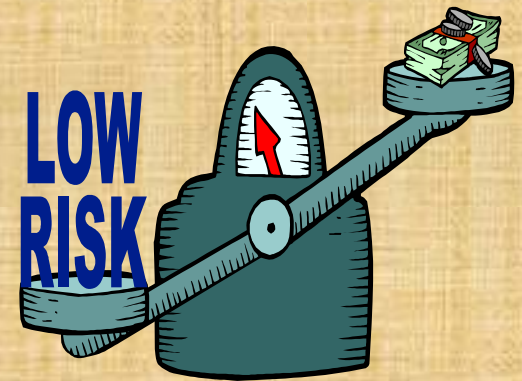
- depart from 'sure thing' block grants and fixed State contracts, but do it *constructively, and*
- encourage creativity, efficiency, and ownership of the managed care rollout by providers. They learn to 'managed the care' of their consumers, too!



**The Good?  
Oftentimes,  
YES.**

# Limited Provider Risk Examples

- **A CASE RATE** is an arrangement in which the State or managed care company pays the provider a contracted *flat rate fee* for each pre-approved enrollee, intended to cover (pay for) a specified 'package' of services which the client may require during a set period of time [such a month or six months]. 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.



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***In a sense, the provider 'manages the care' of the client, rather than the HMO doing so. Case Rates are almost always limited to enrollees with a history of using expensive services – and the goal is to effectively and closely monitor the individual through less expensive, less restrictive, non-inpatient services.***





## Limited Provider Risk . . .

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

Under a Case Rate arrangement, just like a mini-HMO, the provider is 'risking' or 'wagering' that the outpatient services which he must provide to the *majority* of the 'case rate' 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!

# Limited 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.



## Limited Provider Risk . . .

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





# 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.



## **. . . a sort of 'Wrap-Around'.**

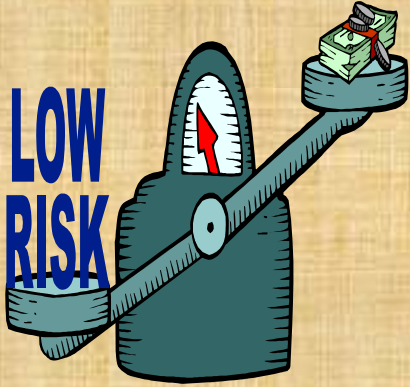
- In fact, SED and SMI clients BOTH do well with this type of flat rate 'wrap around' arrangement [which typically does not require the provider to pay for inpatient and residential care]. Clients are assigned to an Assertive Community Treatment (ACT) Team of individuals (typically including a nurse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




# Pre-Payment for Front-End Assessment and Stabilization.

- **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.*

## Prepayment . . .



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.



## Flat Rate Contract.

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

- ***Another version of the 'Pre-Payment for a specified set of services', but more encompassing. 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 contacts averaging 45-60 minutes.***



## Flat Rate Contract . . .

**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 – provided that you do not have to serve more than the targeted number of individuals.**





# Congratulations!

You have completed Lesson 2 of Module 201. 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 2, Module 201.

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 Lesson 3 of Module 201, return to [My Home Page](#) and click on Module 201, Lesson3.