CURRENT ISSUES IN MANAGED CARE
Presentation Overview

• Key Payment Trends
• Health Care Reform
• Develop a Managed Care Strategy
• Understand the Market
• Understand the Payer
• Monitor Medical Staff’s Managed Care Relationships
• Contract Negotiations
• Payment Structure/Reimbursement Methodologies
• Wrap-Up
SO, ... HOW'S YOUR DAY GOING?
Key Payment Trends

one
- Hospital care represents more than one-third of total hospital spending.

two
- Hospitals are experiencing increasing cost for personnel, drugs, supplies, and other expense areas, workforce shortages, and greater demand for services.

three
- Health insurance premiums slowed in 2011 as employers continued to cut benefits and shift costs to employees.

four
- Major health plans continue to acquire smaller plans and diversify their benefit options and product types.

five
- Hospital collections as a percentage of charges are remaining flat and, in some cases, are decreasing.
Key Payment Trends

SIX
• MCOs are profiling providers in their current networks.

seven
• MCOs will designate more cost effective/higher quality providers as “quality network” providers.

eight
• MCOs creating “Tiered Network” products that use “quality network” providers. Quality rated network will be priced at a significant discount.

nine
• Customers will have the options of buying benefits products that use differing networks.

ten
• MCOs looking to incorporate P-4-P criterion in all network options.
“You never let a serious crisis go to waste. And what I mean by that it’s an opportunity to do things you think you could not do before.”

Rahm Emanuel
Health Care Reform Impact on Medicare Payments

• Market Basket Updates and Reductions
  – Reduces annual market basket updates for inpatient and outpatient services, long term care hospitals, inpatient rehabilitation facilities, and psychiatric hospitals and units
    • Estimated $150+ billion of reduced Medicare reimbursement to hospitals over ten years
  – Reduces Medicare payments by specified percentages to account for excess readmissions (2012)
  – Establishes a hospital value-based purchasing program in Medicare (2012)
  – Establishes a national pilot program to develop paying a bundled payment for inpatient hospital services, physician services, outpatient hospital services, and post-acute care services (2013)
• Medical Loss Ratios
  – Requires health plans to report Medical Loss Ratio (MLR) (2010)
  – Beginning January 2011, health plans that fail to meet minimum requirements will have to issue rebates to enrollees based on difference between minimum standard MLR and actual cost experience
  – Applicable minimum standards are 85% for large group market and 80% for individual and small group market
• Medical Loss Ratios
  – Minimum MLR requirements apply only to insured plans but not to Administrative Service Only (ASO) business
  – Implications are significant to health plans, with impacts on plan design, plan pricing, administration, network contracting, health management, and profitability
Health Care Reform
Implications for Health Plans

• Holds Health Plans Accountable of Unreasonable Rate Hikes
  – Establishes a process for reviewing increases in health plan premiums and requires Plans to justify increases
  – Requires States to report on trends in premium increases and recommend whether certain plan shall be excluded from the Exchange based on unjustified premium increases
Health Care Reform
Implications for Health Plans

• Transitioning to Reformed Payments for Medicare Advantage
  – Restructures payments to Medicare Advantage plans by setting payments to different percentages of Medicare fee-for-service rates (2011)
  – Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements from some Medicare covered benefits than is required under traditional Medicare (2011)
  – Provides bonus payments to high-quality Medicare Advantage plans (2012)
  – Requires Medicare Advantage plans to have medical loss ratios no lower than 85% (2014)
Conclusions

• The effects of health care reform will include:
  – More difficult negotiations with private payers due to increasing regulatory scrutiny of the insurers by federal regulators
  – Movement away from fee-for-service to risk-based reimbursement (pay for performance, bundled payments, global payments, episodic-based care, etc.)
Impact of Managed Care Contracts

Managed Care Contract

Mission

Patient Relations
Net Revenue
Operations
Capital

Physician Relations
Marketing
Managed Care Cycle

- Strategy Development
- Contract Negotiations
- Contract Implementation and Operation
- Strategy Implementation
- Performance Monitoring
- Contract Evaluation
Develop a Managed Care Contracting Strategy

Hospital holds the key to its managed care market and decides which payers will be successful through its contracting decisions.

Do not organize your managed care strategy around the fear of contract exclusion.

Negotiate managed care arrangements with payers that are similar in nature and reflect the importance of the payer to the hospital.

Avoid any arrangement that will give the payer a significant competitive advantage in the market.

Payers should distinguish themselves in the market based on their own quality, service, and price.
Develop a Managed Care Contracting Strategy

Assign all payers to an appropriate discount tier based on surrounding factors

- Volume of Business
- Importance to Hospital
- Prompt Payment
- Significant Physician Participation
- Payment Accuracy
- Admin. Requirements
Develop a Medicare Managed Care Contracting Strategy

Evaluate Medicare Managed Care Products in the Marketplace

- Protect Current Medicare Population
- Obtain Appropriate Reimbursement
- Assess Impact of Utilization Management
Medicare Advantage
Should Your Hospital Participate?

If you are geographically located such that you don’t have to play, then you should consider not participating.

If you are exposed to major out-migration, then you should consider participation.
How To Tell You’re Not Mom’s Favorite
Understand Your Market

Market Assessment for Managed Care Payers Should Include:

- Major Employers
- Enrollment
- Market Share
  - Number of Physicians and Hospitals in Network
  - Negotiating Style/Reputation
  - Financial Position (Net Income, Reserves, Medical Loss Ratios)
Understand Your Market

Market Assessment for All Major Employers Should Include:

- Employees/Number of Covered Lives
- Current Health Insurance Carrier, Products Offered, Policy Renewal Date
- Geographic Distribution of Employees
- Use of Benefit Consultant or Broker
- Relationship to Hospital Board Member
Understand Your Market

Committee should include Senior Staff members and other key hospital staff members

Establish a Consumer Marketing Committee

Committee should make periodic visits to top local employers in order to promote hospital and determine how to better meet their needs
Payers under significant pressure to:

- Achieve market rates, reduce variation in reimbursement rates among hospitals, maximize fixed rate pricing

Payers not just interested in the lowest price

- Also want to obtain a competitive advantage and show their worth to customers through saving reports
Understand the Payer

Payers aggressively pursuing outpatient payment changes, forcing hospitals to consider moving away from percent of charge payment to case payments.

Payers are encouraging members to use freestanding providers due to lower fixed rates and copayment issues.
Payers attempting to exclude traditional hospital services from contracts

- Therapy services, reference lab, clinics, etc.

Payers extremely interested in controlling rates of increase to minimize risks
Payers have COB data that reveals contract rates with competitors

Payers believe that hospital receives 100% of the contracted rates in the agreement
Understand the Payer

Payers seek to shift risk to hospitals:

- **Insurance Risk** – Catastrophic cases
- **Utilization Risk** – fixed rates
- **Inflation Risk** – annual inflation adjustments less than market conditions
- **Legal Risk** – definitions, hold-harmless, indemnification, term, assignment, and termination clauses
Monitor Medical Staff’s Managed Care Relationships

- Track medical staff’s managed care contracting activities, especially hospital-based physicians, on an on-going basis using payer websites
- Monitor potential competitive threats
- Evaluate joint-venture opportunities with physicians
Sometimes When You Are Angry At Someone, It Helps To Sit Down And Think About The Problem.
The movement to complex payment methodologies results in increased need for contract modeling.

Some payers pursue pricing differentials by product.

Hospitals will see significant gains if they can standardize payment methodologies and contract terms.
Inpatient Services

- Percentage of Medicare
- AP-DRGs, DRGs, Per Case by Category of Care, Per Diem by Category of Care, Percentage of Charges
- Stop Loss
- Carve-outs
- High-Cost Items
Payment Structure/Reimbursement Methodology

Outpatient Services

- Percentage of Charges
- Payment Caps
- APCs
- Per Case per Surgical Payment Groups
- Other Per Case Categories (ED, One Day Stays, etc.)
- Per Visit and Per Unit (Radiology and Therapy Services)
- Fee Schedule (Lab)
Never focus exclusively on price; numerous contract terms can affect degree of legal, strategic, and financial risk.

Important to remember that contract was developed for and by the payer.

All terms can be negotiated.
Incorporation of Payer’s Manuals, Policies and Procedures

1. Obtain copy of current manual and review to ensure you are able and willing to comply with policies.
2. Make sure agreement states that nothing in manual can override any term in the agreement.
3. Negotiate reasonable advance notice of all policy changes.
4. Negotiate ability to reopen rate negotiation if policy changes adversely affect your payment.
5. Obtain right to terminate if unsatisfied with policy change.
Offset Provision

- Negotiate to eliminate payer’s ability to offset future payments to hospital as means to recoup money
- Specify process to deal with incorrect payments
Definitions

- Affiliate
- Payer
- Member
- Inpatient Services
- Observation
Claim Submission and Payment Requirements

Establish Reasonable Time Period for Claims Submission (e.g., 180 days from date of discharge)

Include Only Those Claim Elements that are Needed to Pay the Claim Accurately According to Contract

Include Penalty for Claims Not Paid within 30 days

Obligate Payer to Pay All Clean Claims within 30 days
Audit Rights

- Obtain right to audit Payor
- Restrict access to relevant records only
- Require Payer to get member’s release
- Require adequate written notice from payers
- Allow access only during regular business hours
Audit Rights

- Restrict access to mutually convenient times
- Specify the time limits within which an audit can be performed
- Require Payer to following hospital’s audit policy
- Pursue reimbursement for copying and shipping costs
Term of contract often dictated by market conditions

In a competitive market, hospitals may want to negotiate a longer term

The term of contract is not as important if contract can be easily terminated without cause during initial term

Hospital should have right to terminate without cause with reasonable notice (e.g., 90 – 120 days)
Contract Terms and Termination Rights

- If contract contains an evergreen clause, it is imperative that those provisions of the contract which should be negotiated annually are negotiated prior to automatic renewal of contract.

- There should be a provision for termination for cause.

- There should be an opportunity to cure any alleged breach of a contract within a reasonable time.
Many contracts allow payers to unilaterally amend the contracts

- “From time to time”
- “At the Plan’s discretion”

Can significantly change the terms originally negotiated by the parties

Other contracts include automatic amendment of the contracts whenever laws are passed which are relevant to contracts

All amendments to a contract should require the written consent of both parties
Charge Increase Restrictions

- Hospital agrees to notify Payer of any price increases and the Payer will, in turn, adjust the applicable discounted charge amounts to fully offset the price increase.

- May allow Payer to calculate the price increase percentage that will be subject to neutralization.

- Effectively precludes any increase in rates going forward.

- The Hospital should negotiate to include an automatic escalator provision based on fixed annual increase, hospital and related services component of CPI, or Medicare Care component of CPI.
Monitor Contract Terms

- Overall Denial Rate Greater Than 3%
- Specific Recurring Problems with Contract
- Increases in Managed Care Contractual Adjustments
- Warning Signs
- Significant Increases in Denial
- Increases in Days of Accounts Receivable
Monitor Contract Terms

1. Develop Procedures and Electronic Processes for Analyzing Payments
2. Establish a Team to Identify and Research Payment Problems
3. Measure Results on an On-going Basis
4. Communicate with Payer to Discuss Payment Problems/Issues
5. Periodically Report Review Findings to Senior Management
Major Action Steps for Contract Performance Improvement

1. Drive managed care pricing and negotiation strategies with hospital’s business strategy and capital needs.

2. Obtain Senior Management’s involvement and commitment.

3. Develop a contract performance modeling capability... know your target rates for each MCO product.

4. Know your market, range of reimbursement and costs at a detailed level ... be prepared to validate and justify your costs and reimbursement.
Major Action Steps for Contract Performance Improvement

- Understand your importance to the payor and how the market would react should you become a non-par provider.
- Quantify short-term and long-term impact on hospital, physicians, and patients should you go out-of-network.
- Allow sufficient time for negotiation and relationship building...almost everything is negotiable.
- Quantify your business case ... don’t focus on competitor’s rates.
Major Action Steps for Contract Performance Improvement

Negotiate arrangements that are similar in nature and reflect the importance of the payer to the hospital

Avoid any arrangement that will give the payer a significant competitive advantage in the market

Avoid any payment methodology that you can not model, monitor or administer

Never focus exclusively on price; contract terms can affect legal, strategic, and financial risk
Major Action Steps for Contract Performance Improvement

- Standardize payment methodologies and contract terms...integrate with revenue cycle and clinical operations
- Be prepared to walk away from negotiations...develop strategies to retain patients
- Engage employers and brokers...be more than a cost
- Continue to rigorously audit payments for accuracy and inappropriate denials
Major Action Steps for Contract Performance Improvement

1. Take incremental steps to regain control of your revenue cycle as it relates to the administrative requirements contained in contracts.
2. Integrate clinical, billing, and financial departments into the managed care process.
3. Prepare for value-based reform by evaluating your competencies related to integration, risk management, and pricing.
4. Understand current value-based payment models and establish contracting priorities.
After a Long Negotiation
May You Kiss and Make-Up
May You Soar to New Heights in Your Next Negotiation
QUESTIONS AND ANSWERS

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