Basics of Managed Care Contracting

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Basic Elements of a Contract

A contract is **an agreement** between two or more persons or parties **that is enforceable by law**.

- If a party breaks their agreement the other party may seek legal recourse for compensation or specific performance.
- The purpose of a contract is to formalize a relationship between the parties and define the legal obligations each party owes to the other.

- Offer and Acceptance
- Parties
- Legal Purpose
- Legal Capacity
- Meeting of the Minds
- Consideration

Contracts

Therapy Practice Examples

- Employment Agreements
- Real Estate Occupancy Leases
- Supply Purchasing Arrangements
- Software License Agreements

Managed Care Contracts are called

Provider Agreements

Provider Agreement

An agreement between

an insurer* and a healthcare provider**

to deliver covered services to eligible beneficiaries

within their scope of their license and practice

in accordance with certain terms and conditions

in return for monetary compensation.

Offer and Acceptance

Parties

Legal Purpose

Legal Capacity

Meeting of the Minds

Consideration

*or intermediary

** practitioner or practice

Consideration & Compensation

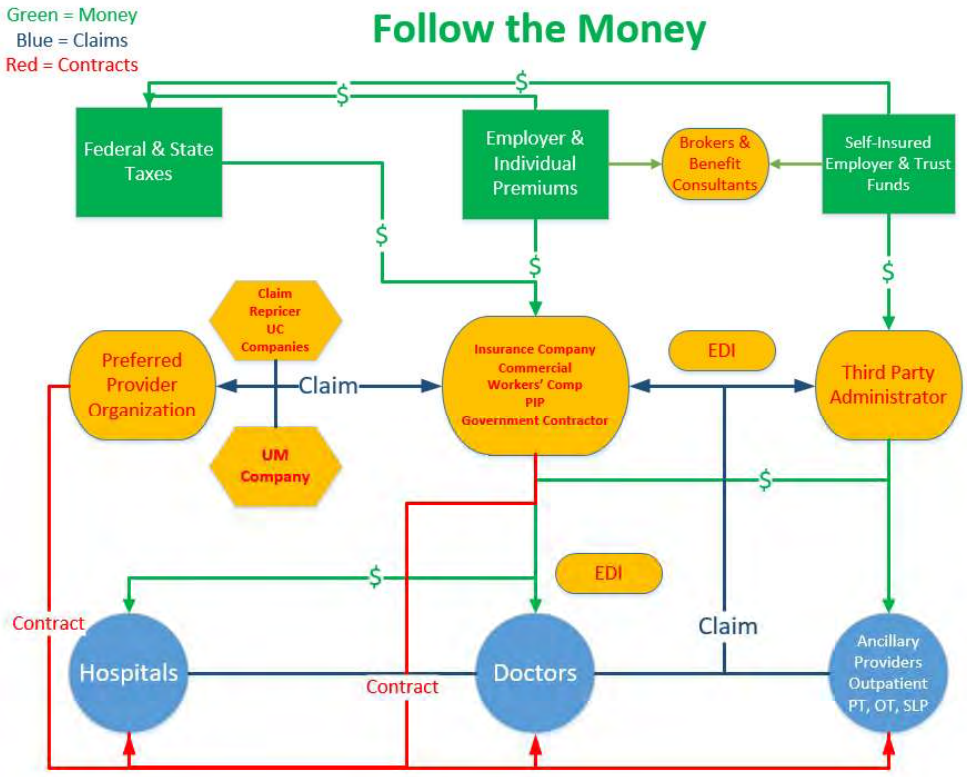
A contract must have consideration to be Legal. **Consideration** is the exchange of value between parties to the contract, (e.g., money in exchange for therapy services), or performance and adherence to specific obligations (e.g. no balance billing, submitting quality data, listing providers in directories, etc.)

Quid Pro Quo - "a favor for a favor"

Payer agrees to incent beneficiaries through benefit features to seek services from provider, known as "channeling," in return for provider's acceptance of obligations, transaction terms and monetary compensation.

A Provider Agreement's consideration that involves monetary compensation is usually an Article, Clause or Exhibit that defines **reimbursement** for services rendered or **prepayment** for services yet to be rendered.

Contracts in the Healthcare System



Patient Populations by Lines of Business (LOB)

- Insurer Employer Health Plans
  - Fully Insured
  - Individual – Small Group, Large Group
  - Self-Insured – Large Group(?)
- Government Health Plans
  - Traditional Medicare
  - Medicare Advantage
  - Medicare Supplements
  - Medicaid
  - Managed Medicaid
- Workers' Compensation Insurance
- Personal Injury Protection (Auto PIP)

Lines of Business – Managed or Unmanaged?

Managed by Provider Agreement and Panels

Insurer Employer Health Plans

- Fully Insured
- Individual – Small Group, Large Group
- Self-Insured – Large Group (ASO and Direct)

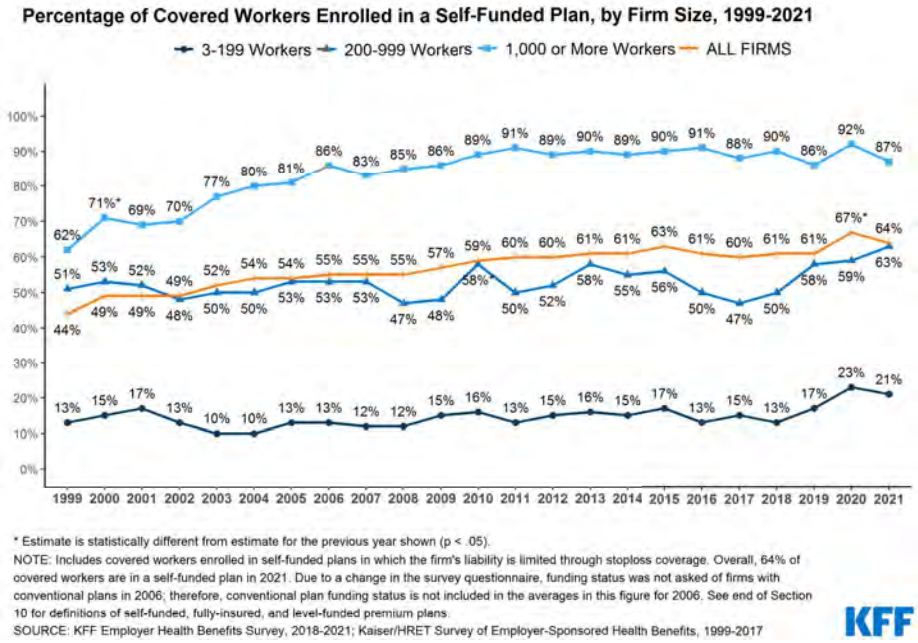
Government Health Plans

- Medicare Advantage
- Managed Medicaid

Not Managed by Provider Agreements and Panels

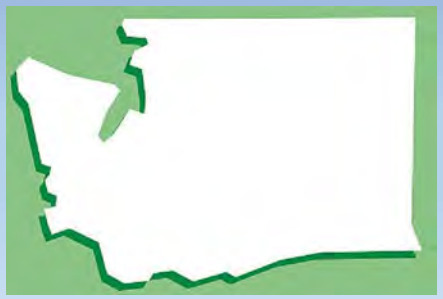
- Traditional Indemnity
- Government Health Plans
  - Traditional Medicare
  - Medicare Supplements
  - Medicaid- "Open Card"
- Workers' Compensation Insurance
- Personal Injury Protection (PIP – Auto MVA)

Administrative Service Organization – ASO LOB



Workers' Compensation
WA Labor & Industry

- A statutory system of no-fault insurance.
- The employee forfeits right to sue employer for job related injuries
- Employer agrees to cover medical and peripheral costs of on-the-job-injury.
  - Direct medical costs, time loss wages, disability
- No out-of–pocket expense for patient



- Employee Choice vs. Employer Choice
- L&I State Fund
- Self Insured Employers

Personal Injury Protection

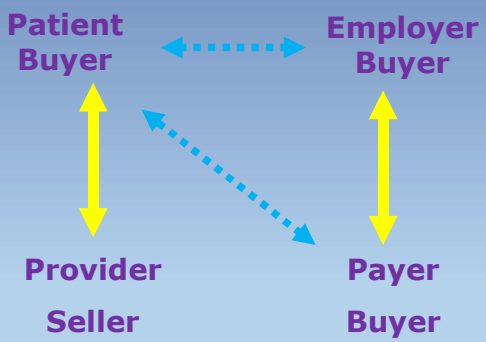
- Washington state law (RCW 48.22.100) does not require PIP coverage, but insurers must offer it to their automobile customers.
- Minimum of up to $10,000 or as much as $35,000 of no-fault insurance coverage for medical expenses per individual injured accident.
- Accident victims may seek medical treatment from their choice of providers with no out-of-pocket expenses up to their limit.

- Bill review companies
  - Usual and Customary Pricing (U&C)
- Discounts without contracts
- The human shield, patient's coverage creates a unilateral discount the PIP payer is willing to defend
- State Laws? – e.g. PIP & State Fee Schedules (ORS 742.525)

Pre-Managed Care Paradigm

Traditional Business

Health Care Business



Pre-Managed Care – Pre-Contracting The Indemnity Health Care Policy or Traditional Policy

- Patients were indemnified for their medical provider bills (reimbursed or used to pay outstanding costs)
- Complete choice of providers
- Patient responsible for medical expenses
- Patient submitted medical bills for "reimbursement"
- Insurance made payment to patient less deductible or co-insurance

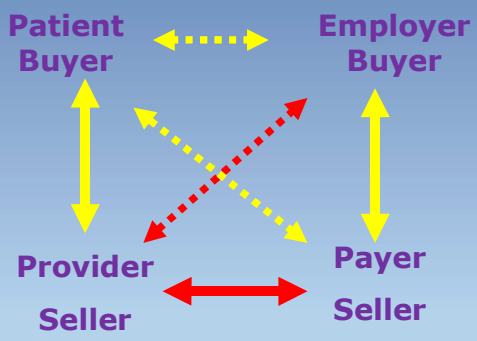
Deductibles – 1st Dollar Paid

Co-Insurance – % of the Bill

Post-Managed Care Paradigm

Traditional Business

Health Care Business



Post Managed Care

- Deductibles – 1st Dollar Paid
- Co-Insurance - % of Bill
- Co-Payments –Fixed Fee Per Visit
- Contracts – Provider Agreements
- Risk Contracting – Capitation, Contact Capitation, Shadow Cap, Per Diems, Case Rates, Global Fees
- Utilization Management Procedures
- Quality Management Programs
- **New Benefit Products**
- **Shifting Provider Alignments**

Are contracts necessary?

Benefits as employee compensation

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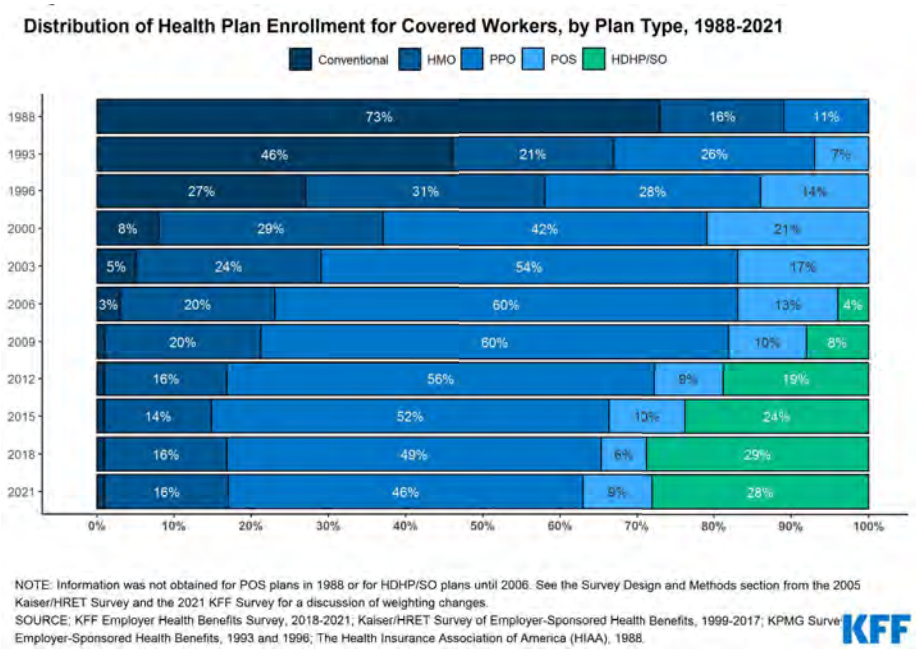
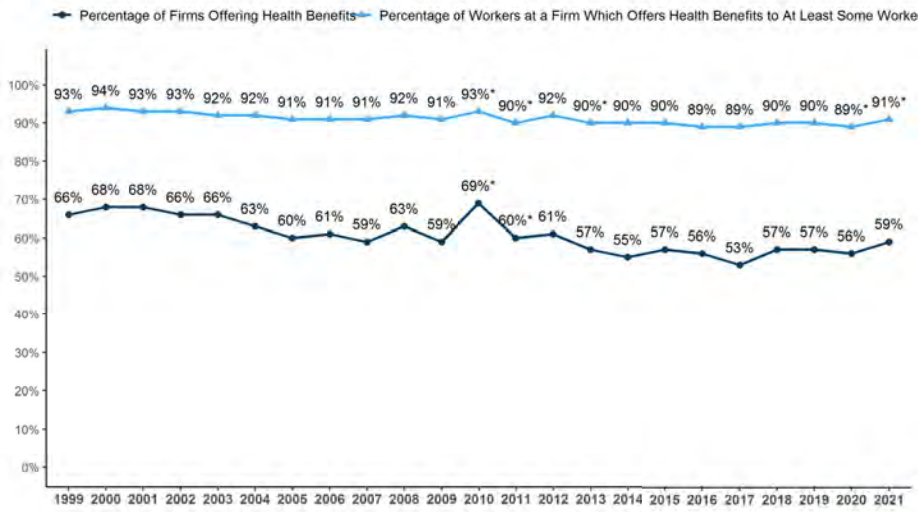


Are contracts necessary?

Benefits as compensation

Percentage of Firms and Workers at Firms that Offer Health Benefits, 1999-2021



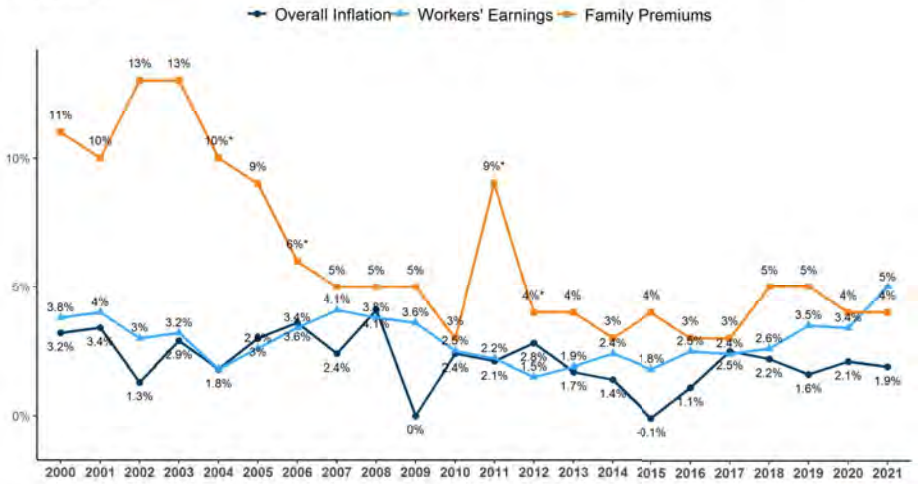
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

KFF

Are contracts necessary?

Diminishing value to benefits as compensation.

Average Annual Increases in Premiums for Family Coverage Compared to Other Indicators, 2000-2021



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SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 1999-2021; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2021.

KFF

Are contracts necessary?

Diminishing value to benefits as compensation
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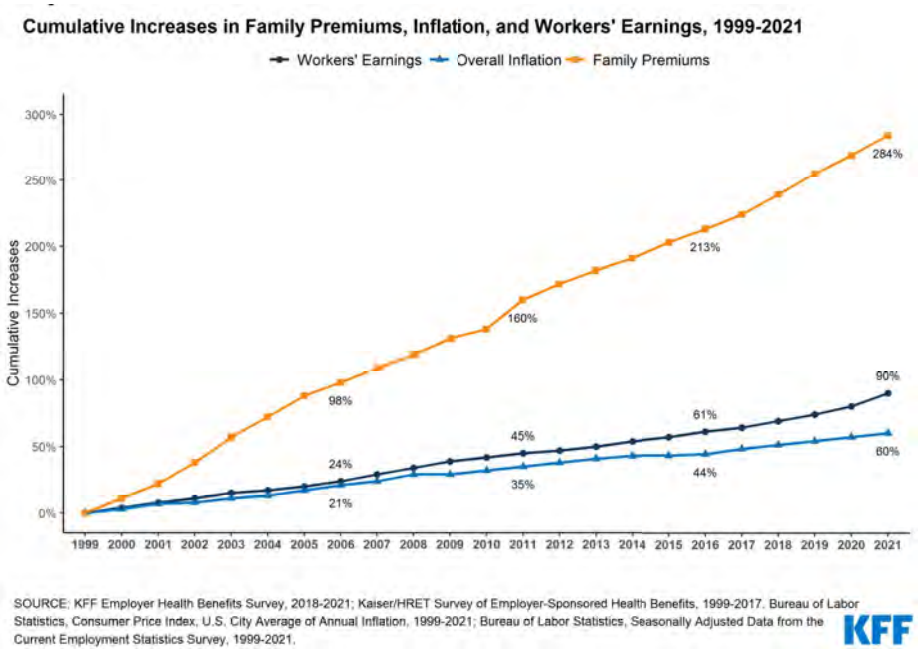


Why do health plans contract with providers?

- Gain market share (employers and employees), grow revenues
- Cost savings from providers
- Savings for their patients and employers
- Manage utilization
- Purchase quality effective healthcare services (?)

Why do providers contract with health plans?

- "Macro" Marketing
  - Increased volumes – market share
  - Align and link with referral sources
  - Align and link with employers and community
- Increase revenues
- Assist patients
- Expedite payment
- Increase profit (?)

The Parties: Provider and Payer and Purpose

- Insurance company that contracts with providers for a discount.
- Insurance companies steer patients to providers with incentives of lower deductibles, and co-insurance amounts.
- Contracted providers become "Preferred" for their willingness to take a discount.

Negotiated Fee Schedule
Agreement not to "Balance Bill"

Competing Motivations?

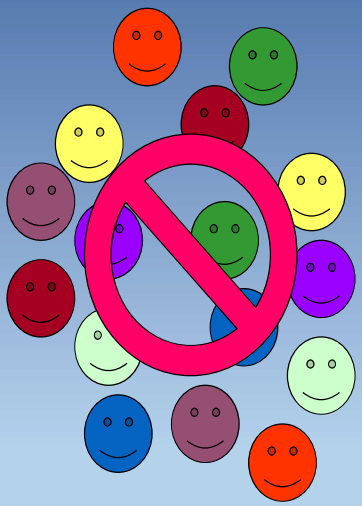
• Provider wants to Maximize Reimbursement	**VS.**	• Payer wants to Minimize Reimbursement
• Provider wants to Maximize Utilization	**VS.**	• Payer wants to Minimize Utilization
• Payer's Maximized Market Share = Threat to Provider Payment	**VS.**	• Provider's Maximized Market Share = Threat to Payer Costs

Managed Care Speak
Health Maintenance Organization (HMO) Benefit

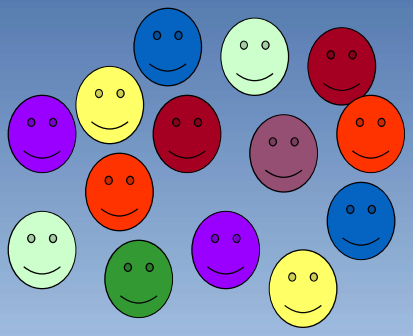
- HMO – PCPs
- Limited Network
- No OON, patients receives benefits only from "in-panel" providers.
- Strong UM – Prior Authorization and Concurrent Review
- Co-Pays
- Possible Tiered – Sub-Panels
  - Lower Payments
- Initially a "pre-paid" or capitation model.

Negotiated Fee Schedule or Capitation Payment
Co-Pay
No Deductible
Agreement not to "Balance Bill"

HMO Benefit



Total Patient Responsibility



Discounted Fee For Service

Limited or No Deductible

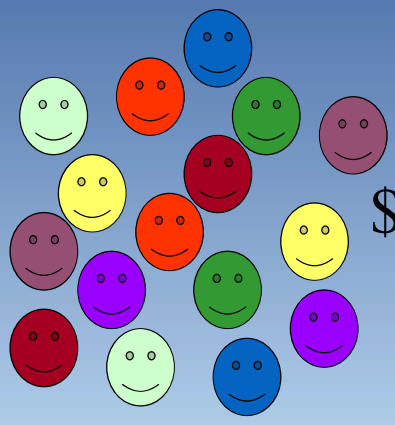
Co-Pay

Preferred Provider Benefit

- PPO – No PCP
- Contracted Network
- Limited UM
- Deductibles, Coinsurance and Copays

Discounted Negotiated Fee Schedule
Deductibles apply to In and Out of Panel Services
Out of Panel Benefits exist, but at higher deductibles
Agreement not to "Balance Bill"

Preferred Provider Benefit



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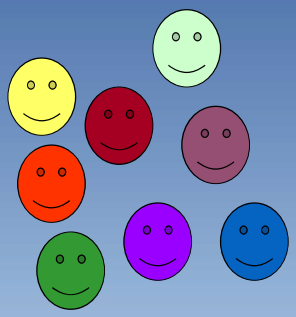


No Discounts

Higher Deductible

Higher Co-Insurance

Discounted Fee For Service

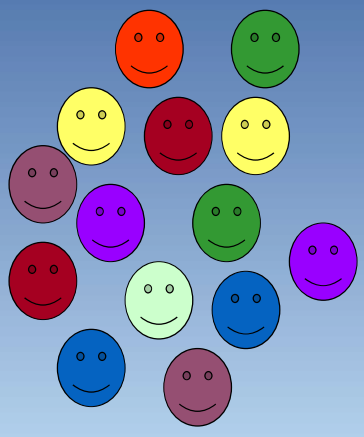
Lower Deductible

Lower Co-Insurance

Point of Service Plan (HMO add-on)

- PCPs
- Strict UM
- Contracted Network
- Incentives to stay “in-panel”
  - Simple co-pays, no deductible
- Reduced OON Benefits
- Option to go “out-of-panel”
  - Co-insurance and deductible.

Point of Service Plan Benefit



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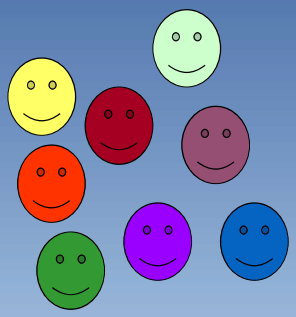


Deductible & Co-Insurance

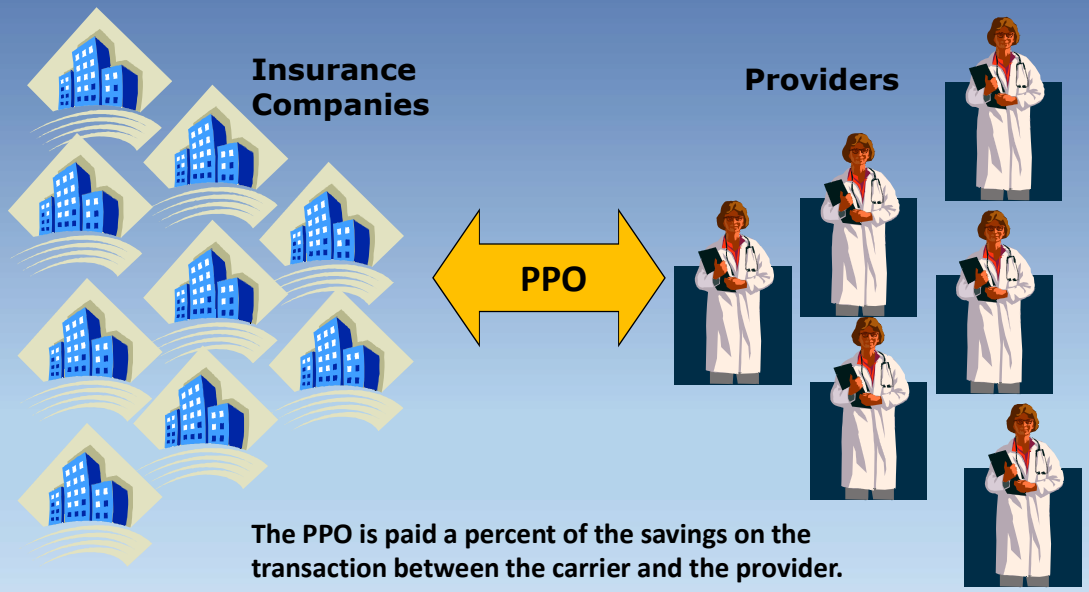
No Deductibles

Co-Pays

Managed Care Speak Homonyms
Preferred Provider Panel vs. Preferred Provider Organizations (PPO)

- Preferred Provider Panel to Serve an HMO, PPO, or POS product. Carrier directly contracts with providers only for its own health insurance products (fully insured or ASO).
  - ASO: Administrative Service Organization - carriers rent their provider network to self-insured employers for access, rates and TPA services.
- Preferred Provider Organization - “For Rent” PPOs –Not a carrier. Contracts with multiple providers ,“rents” their discount to multiple health insurance carriers.

"For Rent" PPOs connect multiple Insurance Companies to multiple medical providers.



The PPO is paid a percent of the savings on the transaction between the carrier and the provider.

For Rent PPOs "Logoed" or "Silent?"

HealthSmart

wise provider networks

Beech Street A MULTIPLAN NETWORK

UMR

PHYSICIANS' HEALTH NETWORK

MAGNACARE℠

First Health

TRPN

America's PPO

coventry AN ENLYTE COMPANY

andros

CORVEL

MultiPlan.

AIM SpecialtyHealth

First Choice Health.

HMA

American Specialty Health.

Carrier Name that has contracted with Multiplan PPO for a discount.

PPO Name

Health Insurance Company

ID Number – 123-45-6789 Group Number 9876

Members Call 800-123-4567

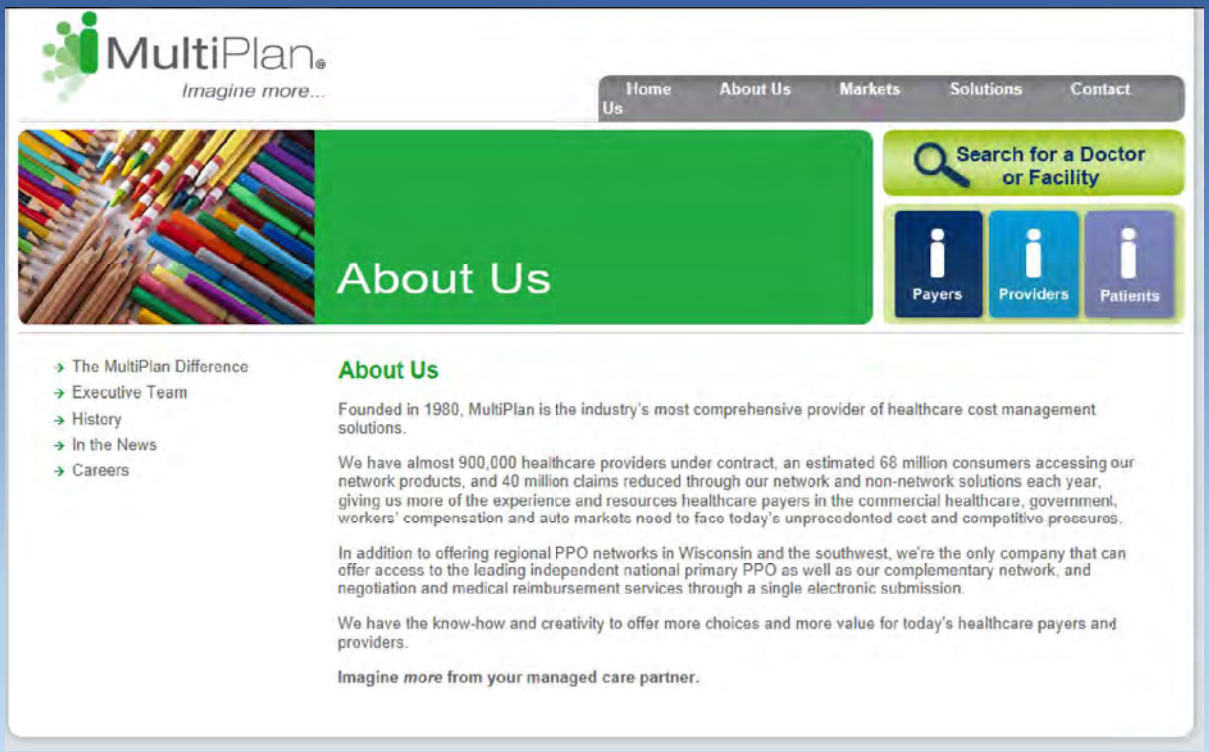
Jim Shorts – 01 For Benefits

Suzie Shorts – 02 Send Claims to

Bermuda Shorts – 03 Lost Mail Department

123 Black Hole Dr.

Seattle, WA 98123



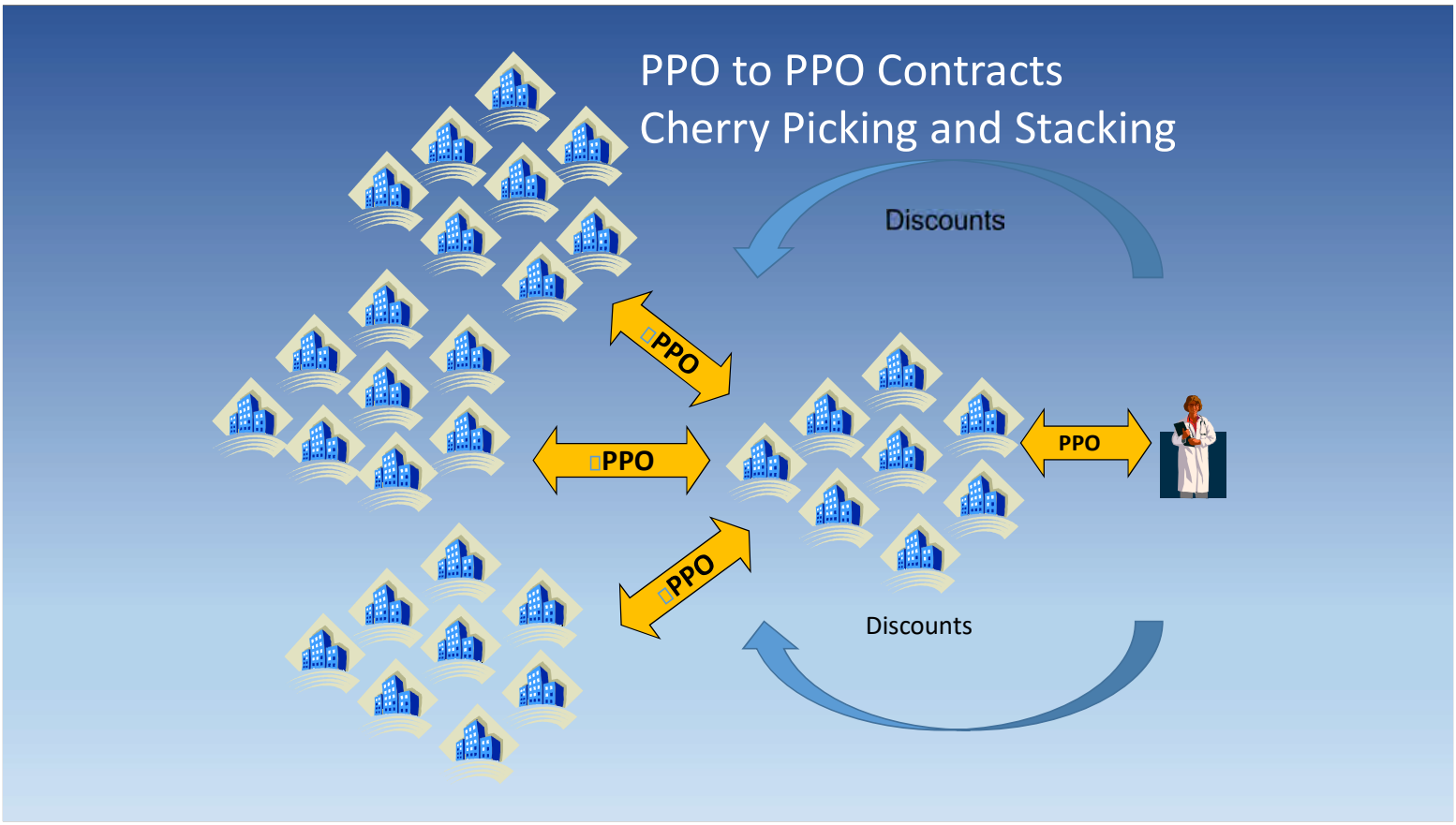
What are Silent PPOs?

- A PPO that is invisible to patients.
- No logo, no provider directory.
- Discount apart from decision by patient based upon a known contract.
- a.k.a. - “ghost”, “non-directed”, or “blind” PPOs.

PPO to PPO Contracting

PPO Cherry Picking & Stacking

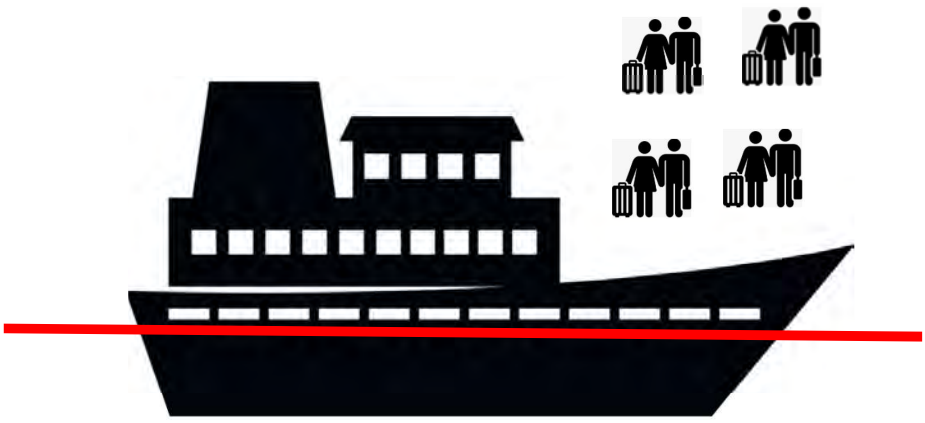
- PPO Cherry Picking - Two or more “for rent” PPOs contract with one another and then “cherry pick” the lowest discount. Providers discount is place din the “deck” to be used if its lowest among the cross contracted PPOs
- PPO Stacking – The linked PPOs “stack” their discounts on top of one another for the same DOS



PPO Contracting

Where's you cost waterline?

PPO Discounts can attract Customers



But large PPO Discounts that go viral can sink you boat.

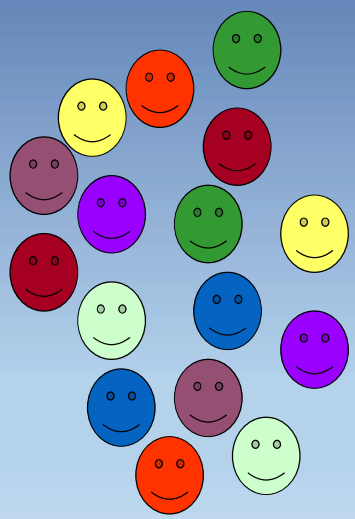
“Expedited” Fee Agreements

Companies asking you to accept a discount in exchange for facilitating “prompt payment” from an insurer that owes a payment.

Examples:

- National Health Quest
- NHBC
- Viant
- MultiPlan Expedited Fee Negotiation Agreement on behalf of Payer United Healthcare (Example: billed charges $490, “expedited price” $218)
- Coalition America

Review - Patient “Channeling” Incentives



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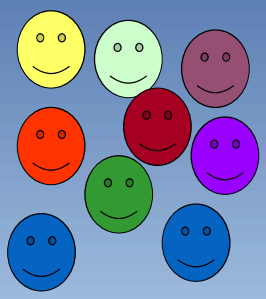
Patient

Contracted Panel Members



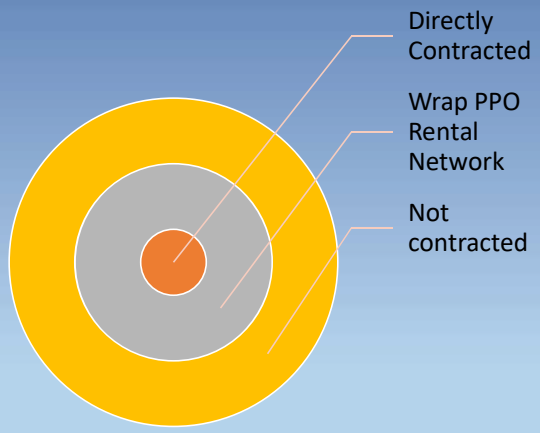
Providers agree to a discounted fee schedule that benefits the patient and the payer.

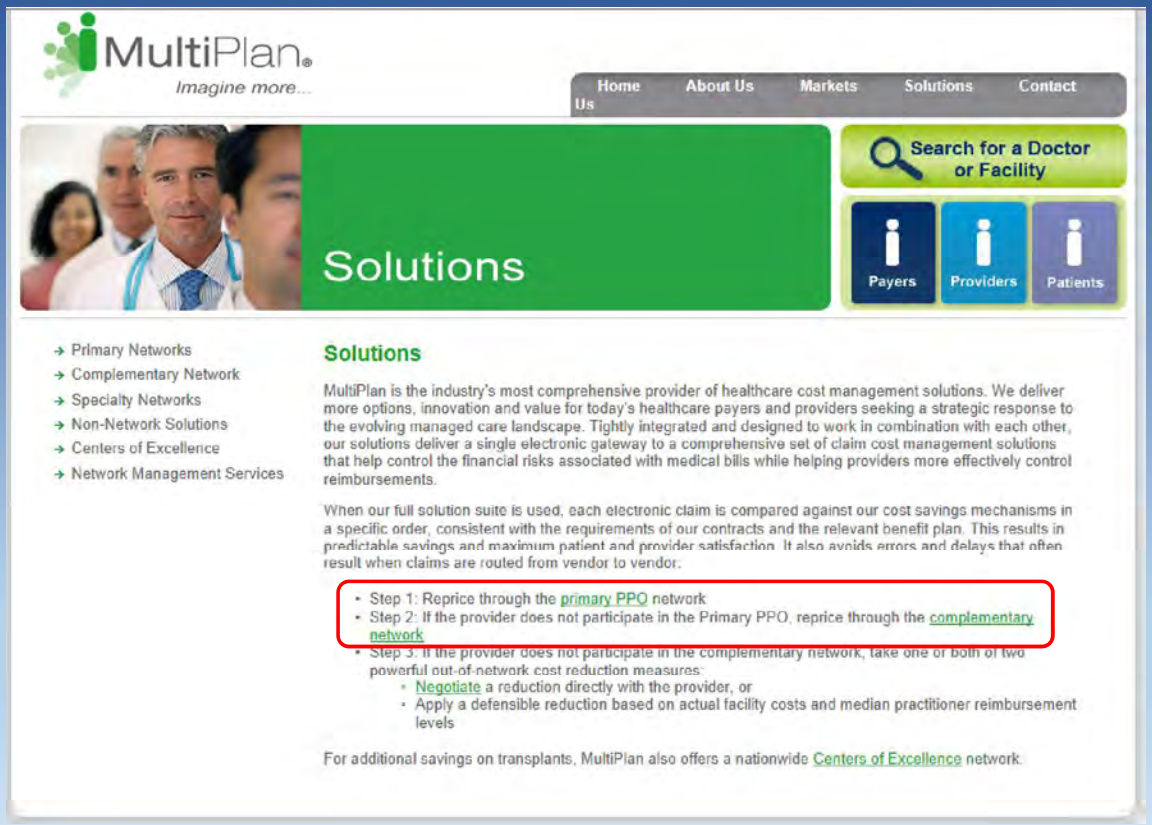
Out of Network vs. In Network

9 visits @120/ Visit	Coverage	Out of Network	In Network	Coverage
Treatment Fee		$ 1,080.00	$ 1,080.00	
PPO Discount	0%	$ -	$ (431.00)	40%
Adjust Fee		$ 1,080.00	$ 649.00	
Deductible	500	$ (500.00)	$ (250.00)	250
After Deductible		$ 580.00	$ 399.00	
Insurance Responsibility	70%	$ 406.00	$ 319.20	80%
Patient Responsibility	30%	$ 174.00	$ 79.80	20%
Total Patient Payment	74.88/Tx	**$ 674.00**	**$ 329.80**	344.20 51% Less

The Wrap Network

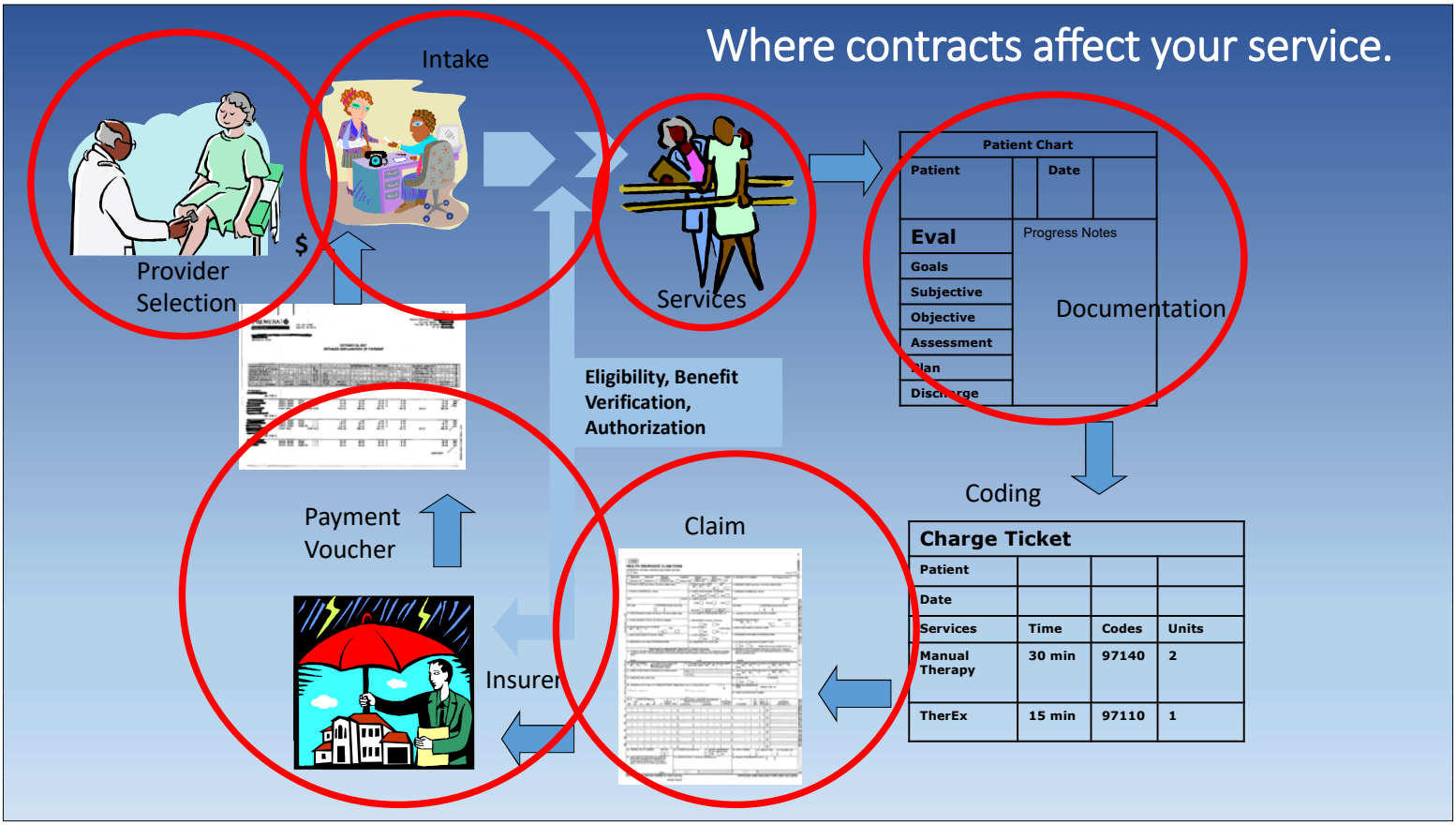
- Carriers directly contract panel
- Carrier rental PPO panel “wraps around” its directly contracted provider panel
- Out-of-network benefits apply to wrap network providers
- Patients and plan benefit from cost containment when directly contracted providers are not selected





Wrap Network Benefit
Out of Network vs. In Network

9 visits @120/ Visit	Coverage	Out of Network	In Network	Coverage
Treatment Fee		$ 1,080.00	$ 1,080.00	
PPO Discount	40%	$ (431.00)	$ (431.00)	40%
Adjust Fee		$ 649.00	$ 649.00	
Deductible	500	$ (500.00)	$ (250.00)	250
After Deductible		$ 149.00	$ 399.00	
Insurance Responsibility	70%	$ 104.30	$ 319.20	80%
Patient Responsibility	30%	$ 44.70	$ 79.80	20%
Total Patient Payment	$60.52/Tx	**$ 544.70**	**$ 329.80**	214.90 39% Less



The Contracting Process

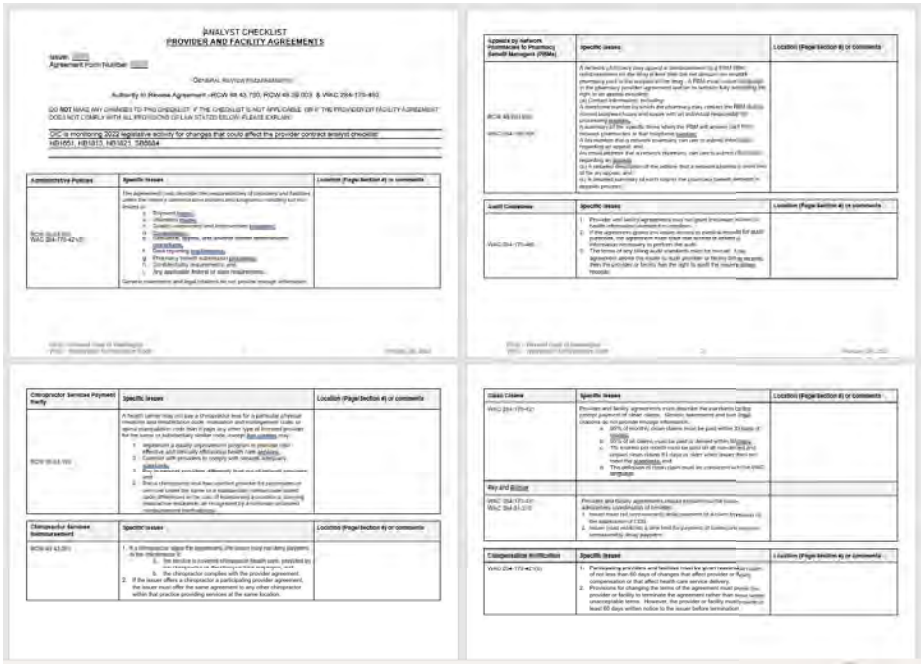
The Contracting Process

- Payer or Provider solicit contract – (leverage?)
- Provider reviews contract (negotiates?)
- Contract is signed (executed)
- Provider undergoes **Credentialing**
  - Practice Application
  - Primary Source Verification (PSV) License, Malpractice (NPDB), Education
  - Entity Committee Approval
- Provider added to contract per an Effective date

Contract Structure
Key Features and Clauses

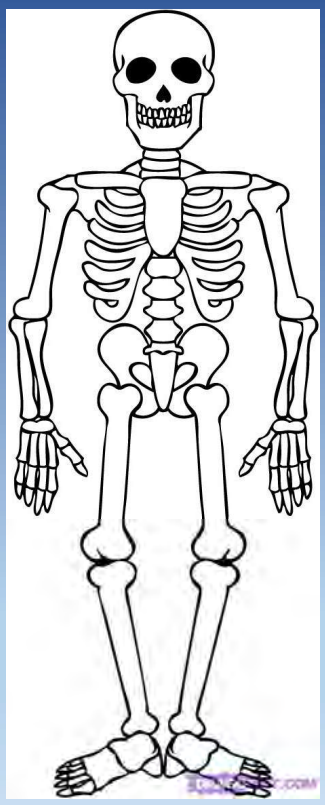
PROVIDER AGREEMENT
TABLE OF CONTENTS

WA Office of Insurance Commissioner Provider Agreement Checklist



ANALYST CHECKLIST
PROVIDER AND FACILITY AGREEMENTS

- Parties
- Recitals
- Meeting of the Minds
- The Agreement
- Definitions
- Obligations of the Parties
- Consideration or Compensation
- Term and Termination
- General Provisions
- Execution
- Exhibits or Amendments



Definitions - Specifically Speaking

- Plan Product
- Member/Enrollee/Worker
- Physician/Referral
- Provider
- Scope of Practice
- Medically Necessary
- Covered Service
- Clean Claim
- Quality Management
- Utilization Management
- Policies & Procedures (Incorporated by Reference)
- Compensation

Example 1- ASO or Rental PPO Provision

Plan Sponsor. An employer, insurer, third party administrator, labor union, organization or other person or entity which has contracted with Company to offer, issue and/or administer a Plan that is not a Full Risk Plan and has agreed to be responsible for funding benefit payments for Covered Services provided to Members under the terms of a Plan.

Example 2- ASO or Rental PPO Provision

Payer - An employer, trust fund, insurance carrier, including but not limited to, **workers' compensation carriers, auto insurance carriers**, health care service plan, trust, nonprofit hospital service plan, a governmental unit, any other entity which has an obligation to arrange or provide medical services or benefits for such services to Members or any other entity which has contracted with XYZ to use a XYZ network of providers.

ASO LOB Opt Out

Product Participation. Company may sell, lease, transfer or otherwise convey to payers (other than Plan Sponsors) which do not compete with Company's product offerings (e.g., workers' compensation or automobile insurers) in the geographic area where Facility provides Covered Services, the benefits of this Agreement, including, without limitation, the Services and Compensation Schedule attached hereto, under terms and conditions which will be communicated to Facility in each such case. For those programs and products which are not health benefit products (e.g., worker's compensation or auto insurance), Facility shall have **thirty (30) days from receipt of the aforementioned notice from Company to notify Company in writing if Facility elects not to participate in such product(s**).

Retroactive Inclusion, Non-Enrolled Members – Silent PPO

"Worker" means any person who has filed a workers' compensation claim against any customer of XYZ under State's Revised Statutes, and is entitled to receive covered medical services. This Agreement expressly applies to all Workers provided with workers' compensation coverage by XYZ-contracted employers or insurers, including such Workers as have **not been enrolled** in the MCO pursuant to ORS 656.245(4).

Another example of Notice to Opt Out vs. Notice to Opt In

New Product Introduction. During the term of this agreement, XYZ may develop/implement new programs that require the services of network providers. In the event XYZ elects to include Provider as a network provider for such programs, XYZ agrees to provide thirty (30) days written notice to Provider prior to inclusion of Provider in the new program**. If Provider does not object writing within 30 days of notice then it will be included in the program.**

Medical Necessity, Scope or License, Covered Services

Covered Services. All of the health care services and supplies: (a) that are **Medically Necessary**; (b) **Provider is licensed** to provide to Members; and (c) that are **covered under the terms of the applicable Member Contract**.

Provider Obligations "Performance Consideration"

- Provide Access
- Deliver Quality Care
- Duty to not Discriminate
- Adherence to Policies & Procedures (QM/UM)
- Timely Filing of Claims
- Timely Appeal
- Payment
- No Balance Billing

No Balance Billing, No Payment without Authorization

Payments to Provider. Provider agrees to accept as payment for the services provided hereunder the amounts and under the terms set forth in Attachment B, and in accordance with the terms and limitations set forth herein. Such **payment shall be accepted by Provider as payment in full** for all Authorized Services. Provider understands that no payment may be made to Provider for services rendered to Beneficiaries which are not authorized by the XYZ.

Payer Obligations "Performance & Consideration"

- Product Channeling of Patients via:
  - Lower Co-Pay
  - Lower Deductibles
  - Lower Co-Insurance
  - Higher Benefits
  - Directory Listings and Card Identification
- Timely Payment
- Accurate Payment

Policies & Procedures Administrative Components
BIR – Billing Insurance Related Costs

- Quality Management
- Credentialing
  - Primary Source Verification
- Utilization Management
  - Prospective
  - Concurrent
  - Retrospective
- New Policies and Procedures
  - Opt –In vs. Opt-Out

Dispute Resolution

- Remedies
  - Good Faith
  - Appeals
  - Mediation
  - Arbitration
- Right of Offset
- Termination

Changes, Additions, Assignments

- New Providers
- Amendments
- New Products
- Notification and Rights Upon Notification
  - Opt–Ins vs. Opt-Outs
- Sale or Assignment
  - By them, By you

Term & Termination

- Term
  - Initial Term
  - Subsequent Terms “Evergreens”
- Termination
  - Without Cause
  - Deadline Before Anniversary Date
  - Deadline Before Calendar Date
  - With Cause –Curing Period

“Evergreen” Renewal Clause

Term and Renewal. This Agreement shall be effective for an initial term (“Initial Term”) of three (3) year(s) from the Effective Date, and thereafter shall automatically renew for additional terms of one (1) year each, unless and until terminated in accordance with this Article 6.0.

Mandatory Term Before Termination Rights

Term and Termination. Termination Without Cause. After the initial twelve (12) month period, either party may terminate this Agreement at any time with ninety (90) days prior written notice, which termination shall be effective the last day of the month following the ninety (90) day notice period.

Initial Term Followed By An "Out" Window

Termination Without Cause. This Agreement may be terminated as of the anniversary date of the Effective Date, by either Party with at least one hundred eighty (180) days prior written notice to the other Party prior to such anniversary date of the Effective Date; provided, however, that no termination of this Agreement pursuant to this Section 6.2 shall be effective during the Initial Term hereof.

General or Other Provisions

- Governing Law
- Severability
- Survivability
- Mutual Indemnification
- Force Majeure
- Headers
- Gender Neutrality

Compensation/Consideration

- Contract Exhibits
  - Specific Criteria
  - Payment Methodologies
    - Fee For Service
    - Per Diem
    - Case Rates
    - Global Rates
    - Capitation

Know the System of Reimbursement

"If you're trying to persuade people to do something, or buy something, it seems to me you should use their language, the language they use every day, the language in which they think."

David Ogilvy, Author, "The Theory and Practice of Selling the AGA cooker,"

Fee For Service
CMS - RBRVS Payment Mechanics

- Relative Value Units (RVUs)
- Budget Neutrality Adjuster (BNA)
- Geographic Practice Cost Indices (GPCIs)
- Conversion Factor (CF)
- Multiple Procedure Payment Reduction (MPPR)
- Sequestration
- PTA/OTA/SLPA - Modifiers

Relative Value Unit - RVU

- Work Expense = Cost of Labor
  - (Budget Neutrality Adjuster)
- Practice Expense = Cost of Overhead
- Malpractice Expense = Risk Factor

Geographic Practice Cost Indices - GPCI

Medicare Administrative Contractor	State	Locality Number	Locality Name	2022 PW GPCI (with 1.0 Floor)	2022 PE GPCI	2022 MP GPCI
02202	ID	00	IDAHO	1.000	0.877	0.416
02302	OR	01	PORTLAND	1.022	1.063	0.535
02302	OR	99	REST OF OREGON	1.000	0.947	0.535
02402	WA	02	SEATTLE (KING CNTY)	1.036	1.194	0.776
02402	WA	99	REST OF WASHINGTON	1.000	1.014	0.744

Traditional RBRVS Formula

(Work Expense RVU X Work GPCI) +

(Practice Expense RVU X Practice GPCI) +

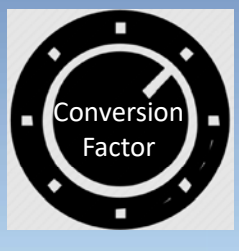
(Malpractice Expense RVU X Malpractice GPCI)

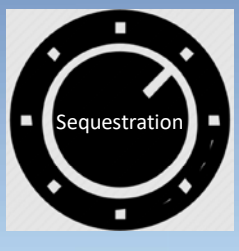
= Total RVUs

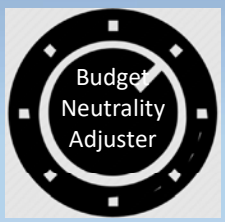
X Conversion Factor

= Allowed Amount

RBRVS – Dialing It In







Medicare 2022					Medicare	34.6062
Effective 1/1/2022		GPCI			% Medicare	100.00%
GPCI	See Below	1.000	1.000	1.000		
MPPR Applies						CF
CPT	Description	Work RVU	PE RVU	Malp RVU	Total RVUs	34.6062
97110	Therapeutic exercises	0.45	0.40	0.02	0.870	$ 30.11
97112	Neuromuscular reeducation	0.50	0.49	0.02	1.010	$ 34.95
97113	Aquatic therapy/exercises	0.48	0.59	0.02	1.090	$ 37.72
97116	Gait training therapy	0.45	0.40	0.02	0.870	$ 30.11
97124	Massage therapy	0.35	0.52	0.01	0.880	$ 30.45
97140	Manual therapy 1/> regions	0.43	0.35	0.02	0.800	$ 27.68
97150	Group therapeutic procedures	0.29	0.22	0.01	0.520	$ 18.00
97161	Pt eval low complex 20 min	1.54	1.35	0.07	2.960	$ 102.43
97162	Pt eval mod complex 30 min	1.54	1.35	0.07	2.960	$ 102.43
97163	Pt eval high complex 45 min	1.54	1.35	0.07	2.960	$ 102.43
97164	Pt re-eval est plan care	0.96	1.04	0.04	2.040	$ 70.60
97165	Ot eval low complex 30 min	1.54	1.37	0.07	2.980	$ 103.13
97166	Ot eval mod complex 45 min	1.54	1.37	0.07	2.980	$ 103.13
97167	Ot eval high complex 60 min	1.54	1.37	0.07	2.980	$ 103.13
97168	Ot re-eval est plan care	0.96	1.05	0.04	2.050	$ 70.94
97530	Therapeutic activities	0.44	0.64	0.02	1.100	$ 38.07

Multiple Procedure Payment Reduction (MPPR)

- Federal Version (WC and state Medicaid programs may differ)
- Practice Expense RVU
  - Highest = 100%
  - Subsequent Codes 50% 2013
- Adjusted Sum x Conversion Factor

Sequester

- 0-2% reductions on 80% CMS paid amount of Allowed

Sequester	
01/01/2022 - 03/31/2022	0%
04/01/2022 - 06/30/2022	1%
07/01/2022 - 12/31/2022	2%

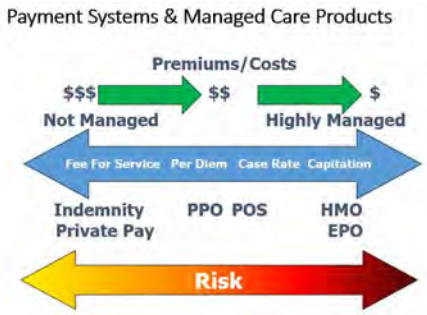
Modifiers

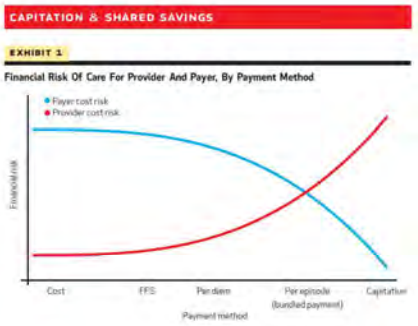
- CQ/CO – PTA/OTA– 15% reductions on 80% CMS paid amount of Allowed
- “di minimis” < 10% of timed service

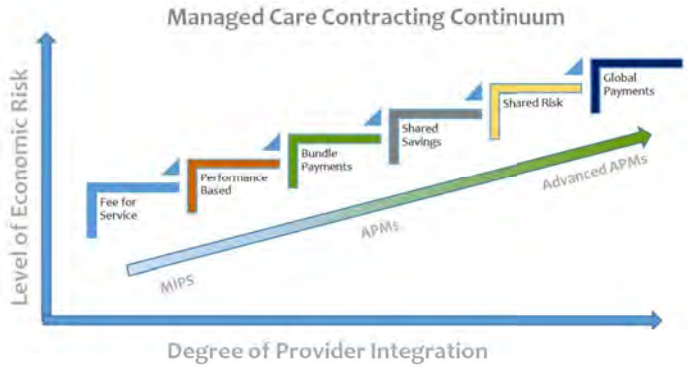
Other Forms of Compensation

- Per Diems
  - The ***lesser of*** billed charges or fixed fee per DOS
- Case Rates - A fixed rate fee per patient per diagnosis per scope of service and a time element
- Global Fee - A finite amount for all services in a bundle across a scope of services for a diagnosis
- Global Budget
  - A finite amount for all services, for a time period
  - Usually ACO/PHO or CCO managed

Payment Methodology







Other Forms of Compensation

Capitation or Global Budget - “population actuarial risk”

Global Budget – FFS, Case Rate, Global Fee

Capitation – A prepayment per member per month (PMPM) for designated scope of service. Capitation - Two forms:

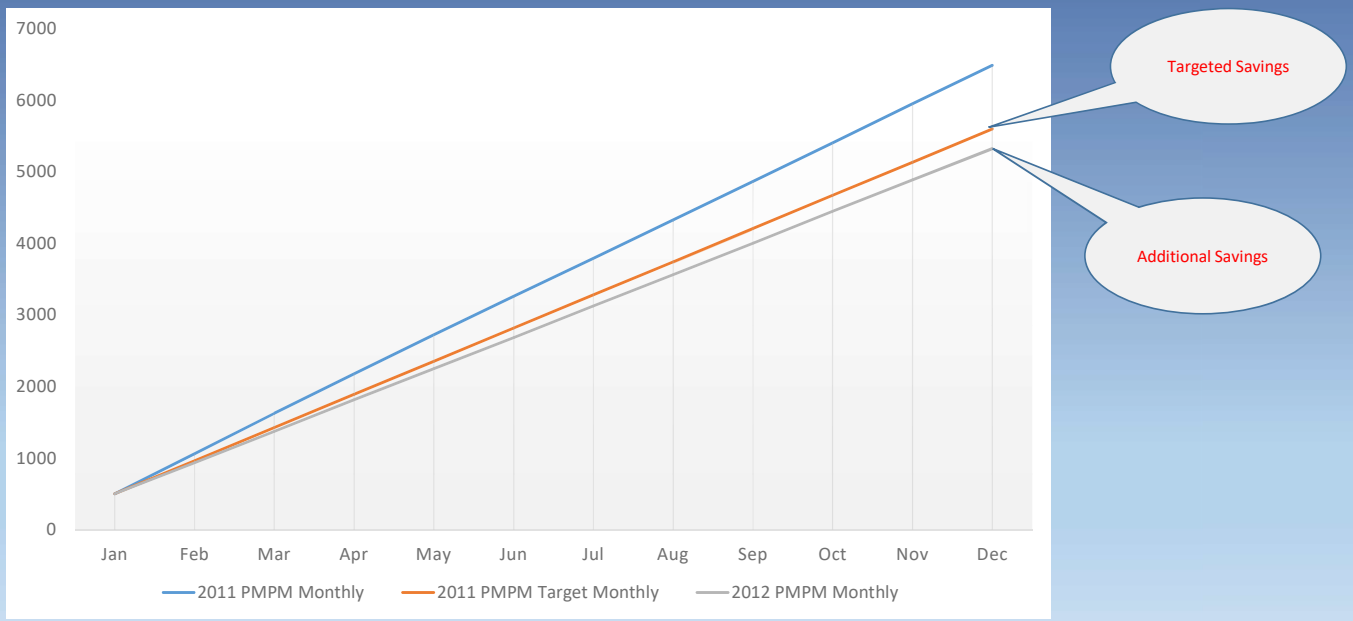
- Pure Capitation - PMPM
- Contact Capitation –A pro rata referral payment from a set budgeted PMPM pool of funds. Case Rates that fluctuate.

Other Forms of Compensation

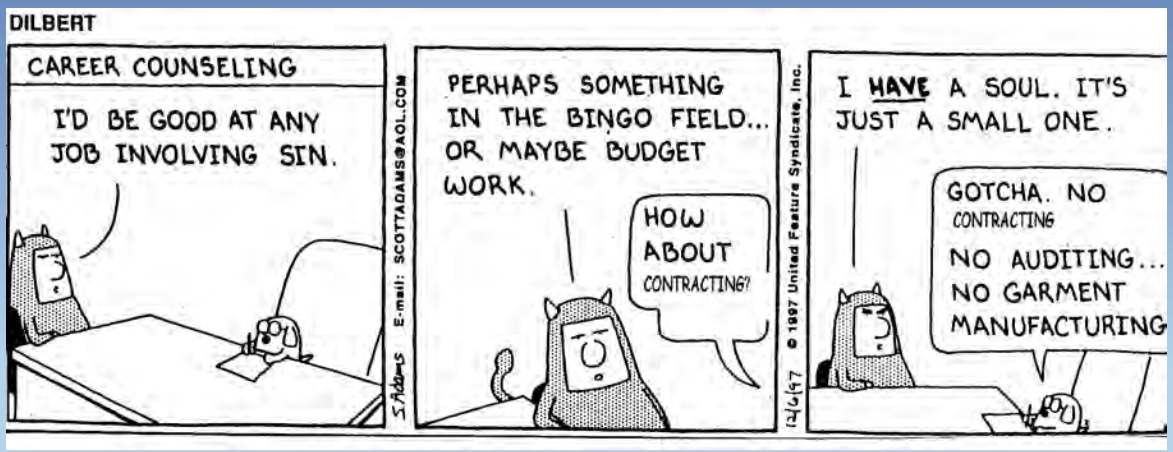
- Shared Savings (Shadow Capitation)
  - PMPM target budget
  - Negotiated FFS - Usual claims and payment
  - Risk withhold
  - Settlement of withheld funds

Any form of Capitation or Risk assumption should be carefully assessed and managed with appropriate stop losses and risk corridors to mitigate provider downside.

Fee For Service Payment Accumulates Against Prior Year's Target



Managed Care Contracting
Pitfalls, Preparation, Process, Performance



Your Practice

- Practice Service Lines
  - PT, OT, SLP
  - Ortho
  - CHT
  - Pediatrics
  - Pelvic Floor
- Referral Alignments
  - Physicians, Employers
- Practice Service Model
  - 1:1 60 Min, 40 Min, 30 Min
  - PTA, OTA, SLPA
- Practice Competition
  - Proximity
  - Service Line
  - INNET or OON
- Cost of Care
  - Per DOS, Cost Conversion Factor

Contract

- Payer Lines of Business
  - Commercial Fully Insured Self Insured - ASO
  - Medicare Advantage
  - Medicaid
  - WC/Auto
- Benefits Per LOB
  - HMO, POS, PPO, Traditional
- Network Size
  - Open, Tiered, Narrow (EPO)
- Payer Competition
  - Monopsony – Oligopsony
- Administrative Burden
  - Eligibility Benefits, Website, Payment Performance
  - Prior Authorization, Concurrent
  - Credentialing & Compliance
- Payment Method and Rate
  - FFS, DOS
  - Case Rate/Bundled
  - Capitated/Global Fee

The Payer's Contracting Tactics

1. "We will bring you volume through channeling of our membership to you in return for cost savings and to get this product off the ground."
2. "We have a significant membership in need of additional access, so we need to grow the panel."
3. "Our rates are higher than our competition, so we need their rates to compete."
4. "Accepting our rates is the discount you need to take in order to see our patients."

Pitfalls: Promiscuous Contracting

"We have met the enemy, and they are ours."
Oliver Perry, Commodore United States Navy

- PTs value participation, trumping payment levels
- Helping patients to avoid deductibles, co-insurance or co-pays
- Attachment to referral sources
- Make it up on volume false assumption
  - do the math
  - know your costs
  - know your payer mix

Pitfalls: Over Discounting, the law of diminishing returns.

"If you're selling your service at below your cost, the more you advertise the faster you go broke."

Gordon Moore, Co-Founder Intel

Cost of Care

- Fixed Costs
  - Costs that don't change regardless of volume
  - Rent, insurance premiums, equipment leases
- Variable costs
  - Costs that increase as volume increases
  - Hourly wages, supplies, laundry

Contracting Discounts to Achieve Profits/Losses

	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5	Scenario 6
Capacity	1000	1000	1000	1000	1000	1000
Actual Treatments	850	880	910	940	970	1000
Percent of Capacity	85%	88%	91%	94%	97%	100%
Revenue						
Effective CF Rate	40	39	38	37	36	35
RVUs/Visit	3.5	3.5	3.5	3.5	3.5	3.5
Revenue/Visit	140	136.5	133	129.5	126	122.5
Netw Revenue	$ 119,000	$ 120,120	$ 121,030	$ 121,730	$ 122,220	$ 122,500
Expense						
Less Fixed	$70,000	$70,000	$70,000	$70,000	$70,000	$70,000
Variable Cost/Visit	$28	$28	$28	$28	$28	$28
Variable Costs	$23,800	$24,640	$25,480	$26,320	$27,160	$28,000
Total Cost	$93,800	$94,640	$95,480	$96,320	$97,160	$98,000
Profit/Loss	**$25,200**	**$25,480**	**$25,550**	**$25,410**	**$25,060**	**$24,500**
Profit Margin	**21.18%**	**21.21%**	**21.11%**	**20.87%**	**20.50%**	**20.00%**

Converting Your Costs to a Conversion Factor

Total Each CPT Code Billed

X

RVUs per CPT Code

= Total RVUs

/

= Total Cost/RVU

= Cost Conversion Factor

Negotiating – Art and Science

Current Assumptions		New Assumptions
The keys to a successful negotiation are compromise and concession.		The key to a successful negotiation is creativity.
My best tools are statements of "Yes or No," "I'll give X if you give Y," and "Or Else."		My best tools are the questions, "What's driving that?" "How would we defend that and based on what standard?" and "What are some ways you think we might solve this?"
My main job is to get our message across.		My main job is to fully understand their perceptions and interests and engage them in joint problem-solving.
I am most persuasive when I know and show that I am right.		I am most persuasive when I think and show that I am open to persuasion, and when I truly believe I have at least a 1% chance of being "wrong" or can learn something from them.
Power comes from using force or financial and material leverage.		Power comes from driving understanding, creativity, and a fair process.
The only way to get something is to give them what they want.	**Versus**	If we can understand "why" they want something, we can discover more and likely better possible solutions.
If we give now, we can get later.		Creating fair, equal agreements that manage both parties' abilities for follow-through is more effective in the long run.
Failure is their problem.		Failure is a joint problem.
There are only two choices in negotiation: be a hard (anchor positions and make threats) or a soft (give in to build the relationship) negotiator.		The most effective negotiator knows his / her walk-away and has it in his / her back pocket, builds the relationship (develops trust on actions, not concessions), and negotiates substance on the merits (making use of interests, options, and legitimacy).
If they behave badly, I should too.		I should behave in a way that will move us toward where I want to go.
This negotiation is an isolated, transactional event.		The purpose and desired outcome for this event builds upon and sequences with past and future engagements.

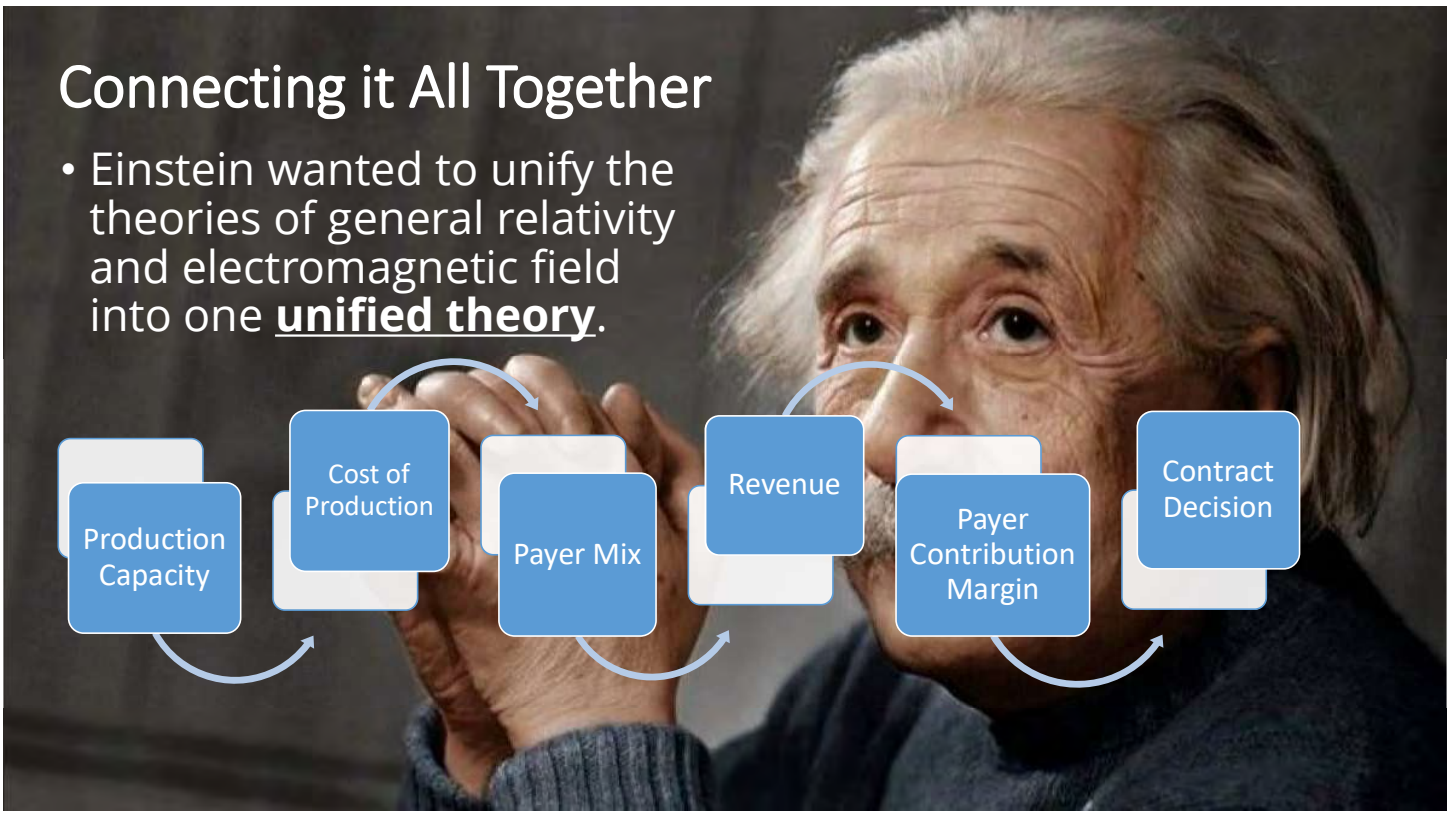
Do you know your cost of care?

"It shocked me, coming from the fast-food world, where everything about costs is known, to shift into the healthcare world, where oftentimes, providers have almost no idea what their true costs are to deliver services."

Mark Hagland - The New England Journal of Medicine (1998)

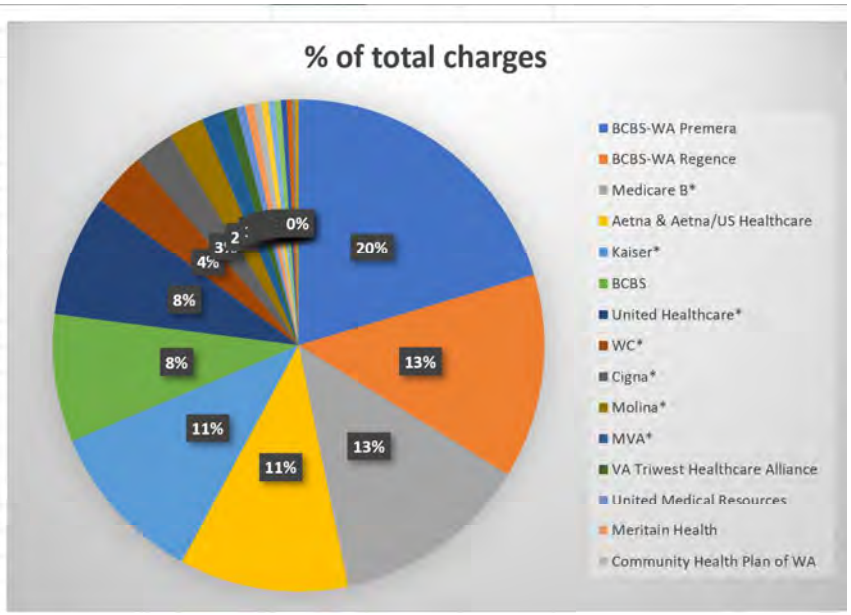
Preparation - Know Your Cost of Care!

- Fixed Costs
- Variable Costs
- Capacity and Incremental Pricing
- Break Even Point
  - Per Treatment
  - Per Referral



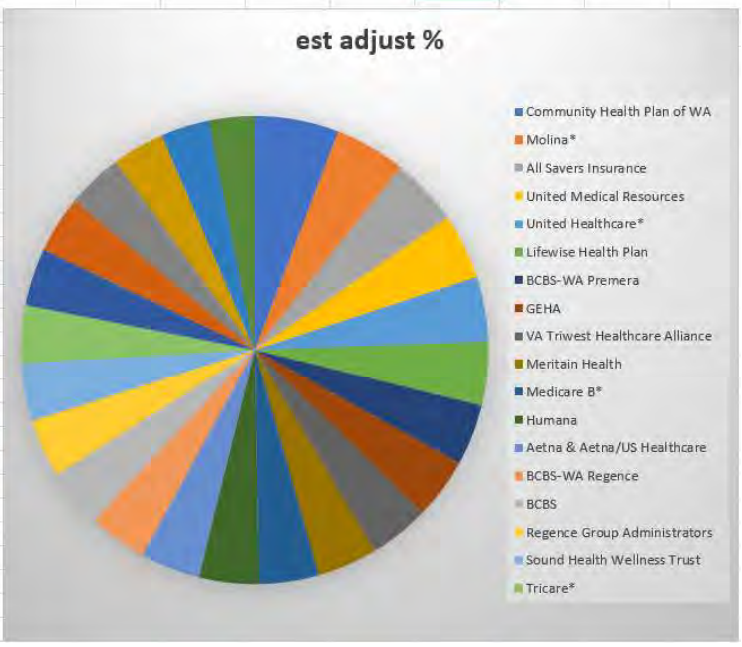
WA Payor Mix

WA Puget Sound	% of total charges
BCBS-WA Premera	20%
BCBS-WA Regence	13%
Medicare B*	13%
Aetna & Aetna/US Healthcare	11%
Kaiser*	11%
BCBS	8%
United Healthcare*	8%
WC*	3%
Cigna*	3%
Molina*	2%
MVA*	1%
VA Triwest Healthcare Alliance	1%
United Medical Resources	1%
Meritain Health	1%
Community Health Plan of WA	1%
Lifewise Health Plan	0%
First Choice Health (WA)	0%
Self-Pay (cash)	0%
Healthcare Management Admin	0%
Regence Group Administrators	0%
Humana	0%
Tricare*	0%

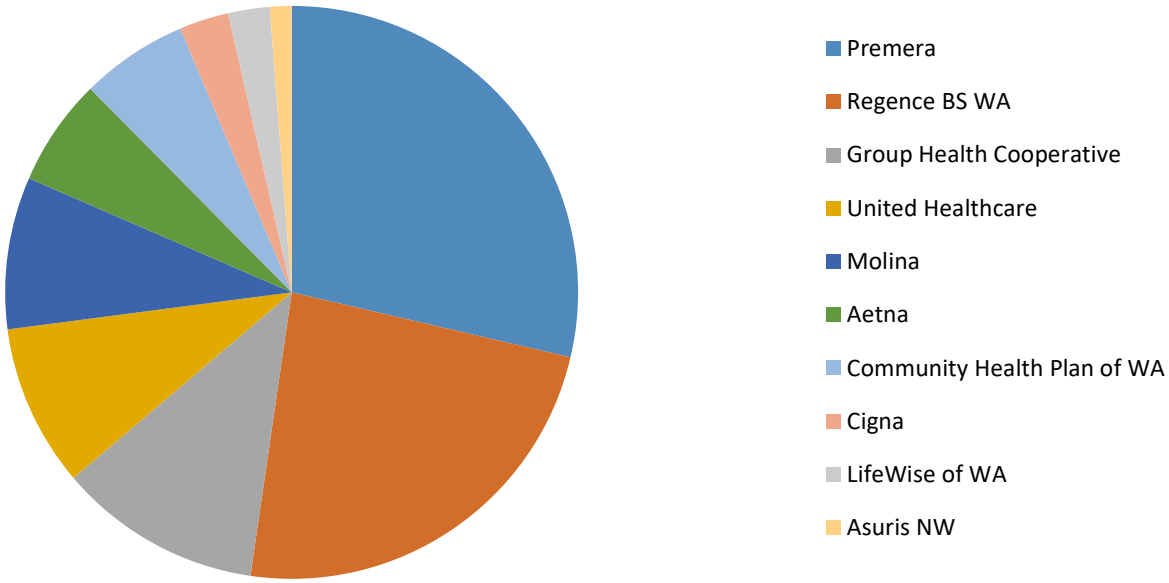


Payers By Adjustment Percentage

WA Puget Sound	est adjust %
Community Health Plan of WA	88%
Molina*	74%
All Savers Insurance	71%
United Medical Resources	68%
United Healthcare*	68%
Lifewise Health Plan	67%
BCBS-WA Premera	64%
GEHA	64%
VA Triwest Healthcare Alliance	63%
Meritain Health	63%
Medicare B*	63%
Humana	63%
Aetna & Aetna/US Healthcare	63%
BCBS-WA Regence	61%
BCBS	61%
Regence Group Administrators	61%
Sound Health Wellness Trust	61%
Tricare*	61%
First Choice Health (WA)	60%
Cigna*	60%
Kaiser*	58%
Providence Health Plan	55%
WC*	51%
Healthcare Management Admin	48%
MVA*	0%
Self-Pay (cash)	0%

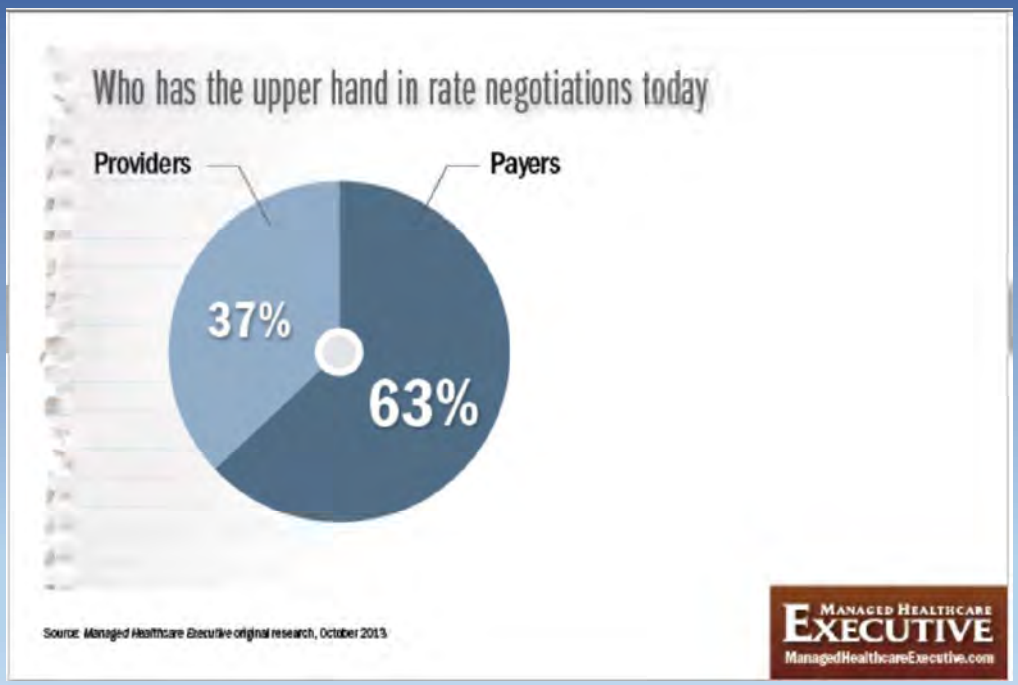


WA Commercial Enrollees Oligopsony Market Conditions



Market Economics

An **oligopsony** a market form where the number of buyers is small and the number of sellers is large creating imperfect competition.

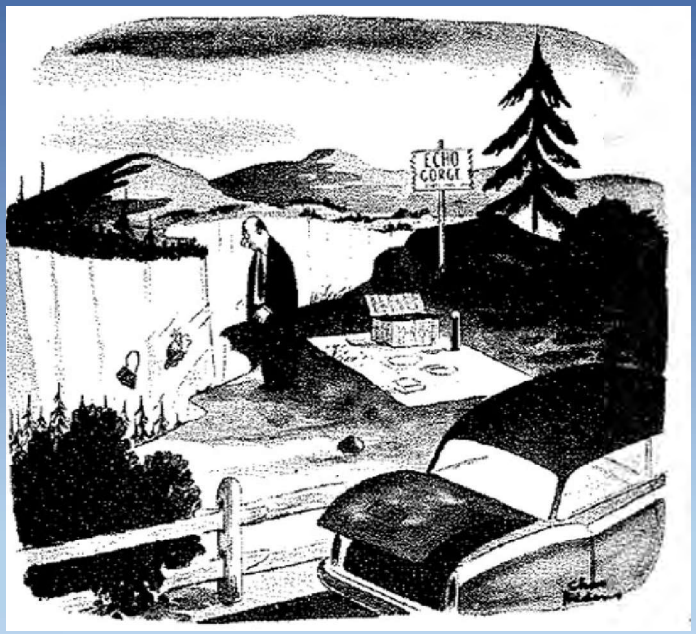


Brinksmanship?

You wouldn't dare!

You wouldn't dare!

You wouldn't dare!

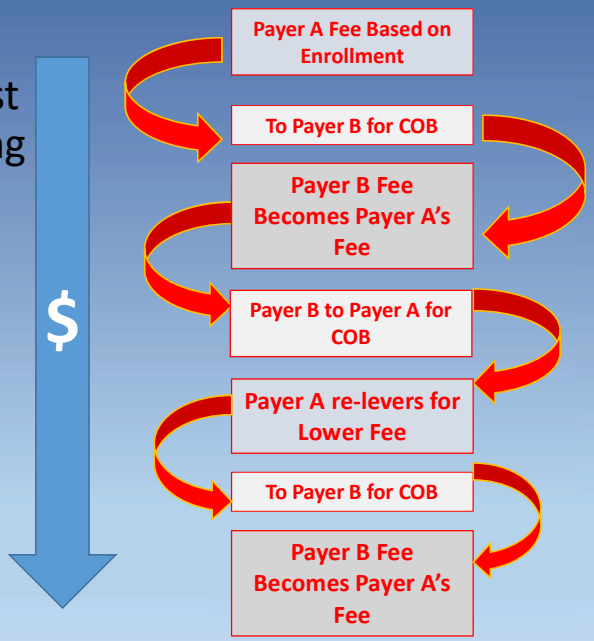


Pitfalls: When Your Best Customer Becomes Your Worst Enemy

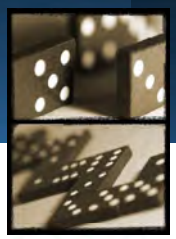
- Capacity Oversold to a Single payer
- Fees below your cost
- Beware the claim for "Parity Pricing."
  - a.k.a. - Most Favored Nations Clause

Parity Pricing – The Death Spiral

- Payer Mandated "Most Favored Nation" Pricing
- Single Payer Pricing from a Multiple Payer System
- Lowest Payment at Highest Cost



The Domino Theory?



Business Journal

Friday, January 29, 2010

Therapists pained by new Anthem Blue Cross plan

Silicon Valley / San Jose Business Journal - by Mary Duan

Anthem Blue Cross patients may find it harder to find physical, speech and occupational therapists willing to treat them, and they may have to reach deeper into their pockets to pay for those who will care for them.

The situation comes as a result of the WellPoint Inc.-owned insurer's move to lower its reimbursement rates to a flat fee of $75 a visit.

Members of the three so-called rehabilitative care disciplines met with the California Department of Managed Health Care on Jan. 26 in Sacramento to discuss whether the new fee structure is risking patient access to care. If the department finds it does, and Anthem doesn't move to correct the problem, the state could move to fine Anthem.

Ross Nakaji, founder and CEO of Los Gatos Orthopedic Sports Therapy Inc., said his office started contracting with Anthem only last fall and will not agree to the new fee structure. Any patients covered by Anthem Blue Cross will be considered out of network and pay accordingly.

"Did signing with Anthem last year help? Absolutely. Are we going to re-sign? No," Nakaji said. "In order for us to maintain the quality of what we do, we see one patient an hour, and there is no way we would be able to see one patient an hour at that reimbursement rate.

"My take is that if we agree to these changes, we're giving permission to the insurance companies to say our services aren't worth very much."

Depending on the services, the new reimbursement represents a reduction of between 25 percent and 200 percent.

A contract with the national Physical Therapy Provider Network provided a billing mechanism under which physical therapists were reimbursed based on the services they provided, usually between $90 to $140 a visit.

Under the provisions of a new offer from Anthem, the network is cut out of the equation. Individual physical therapists that agree to the new contract would receive a flat rate of $75 a visit — an amount some say is not sustainable.

Be a Prudent Contractor, Set your Contract Guidelines

"Insanity is doing the same thing over and over expecting different results"

Albert Einstein, Benjamin Franklin, and others

A Tilted Playing Field

- No one's terminating
- Fees accepted mean fair payments
- "Coordination of Benefits" data
- Antitrust laws

Preparation

- Are they replaceable?
  - Volume and cost
- Are you replaceable?
  - Understand supply and demand in your market
- Are there leverage points?
  - Local employers, influential people, utilization profile, good marketing creates leverage

The Principles of Negotiation

"You can't always get what you want, but if you try sometimes, you just might find, you get what you need."

Mick Jagger, London School of Economics

Terms, Conditions, Definitions, Policies and Procedures:

Ask, it's the only way to find out what's negotiable.

- Lines of business?
- How is credentialing handled?
- Will all providers in your clinic be credentialed?
- Will all your sites be under the contract?
- Are Locum Tenens permitted?
- Are you allowed to leave the contract in a timely manner?
- Does assignment provision protect you if the payer or PPO is purchased?
- What are prior authorization procedures concurrent review?
- What constitutes timely filing?

Contract Work Sheet

The Principles of Negotiation

- First offer – who makes it, is it firm?
- Timing - does the payer need you?
- You're not negotiating unless you are willing to walk away from the table.
- "It's not personal, it's only business"
- Know your value

Know your value and know how to sell it!

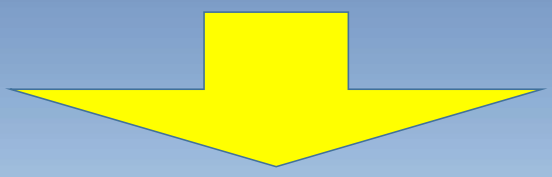
- Conservative and cost effective
- Savings in imaging, surgery, pharmacy, and hospitalization
- Aids employee fitness and wellness
  - Absenteeism Presenteeism (improved productivity)
- Reduced disability and time loss payments
- Reduced premium costs
- Part of disease management "diabesity" - a national epidemic

Value = Quality/Price

- A combination of effectiveness and cost.
  - Effectiveness - is the patient reaching a desired outcome?
  - Cost –what is the expense of all resources to get the desired outcome?
  - Value = The ratio of outcome to total cost.

The Value Proposition

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$



$$\text{Value} = \frac{\text{Clinical Outcome Data} + \text{Patient Satisfaction Data}}{(\text{Units} \times \text{Price}) - \text{Savings}}$$

Value Example:

Total cost per episode is lower but reimbursement per treatment is higher. If utilization is appropriate and outcomes are reasonable, both parties win.

Treatments	Rate/Tx	Cost / Episode
12	$ 75	$ 900
9	$ 95	$ 855

Do you know your value profile?

Know your quality and know your cost.

- Insurance Companies Profile you by
  - what you bill them
  - what you will accept
  - by NPIs, Tax IDs, lines of business
- And now by quality metrics? Or only Utilization Metrics?

Be Part of the Solution

- Know the “Big Picture” of your market
- Understand stakeholders – be a “solution provider” and not simply a “victim”.
- Manage your utilization and quality profile
  - Collect outcomes and patient satisfaction data.
- Join an IPA
- Be a prudent business person, a weak industry affects all providers

Caveat Venditor
Deal Breakers?

- Most favored nations clauses; parity pricing.
- Unilateral assignment notifications and rights.
- Unilateral fee change provisions; no opt outs.
- All or nothing business lines
  - channeled and non-channeled patients
- Some providers vs. all providers
- Some locations vs. all locations
- Services outside your scope
- Fee Schedules unreasonably applied to non-covered services

Caveat Venditor
Deal Breakers?

- Costly or unreasonable authorization, billing and claims processing procedures
- Short claim submission windows
- Short appeal submission windows
- Liability costs that are too high
- Non-reciprocal hold harmless provisions
- Terms (contract durations) too long
- Commercial fees that float e.g Medicare
- Unreasonable hours of operation and location requirements

Contract Performance

After the contract is signed, then what?
Be careful what you wish for.

A man who carries a cat by the tail learns something he can learn in no other way.

Mark Twain

Contract Performance

- Correct payment?
- Timely payment (95% or above?)
- Timely claim projects?
- Reasonable appeals process for provider issues of non-payment or incorrect payment?
- Timely provider credentialing and load dates?

Contract Performance

- Accurate identified in payer's claim systems, directories (web based)?
- Communication is timely, relevant, and in writing for changes in reimbursement, policies denying for specific codes and prior authorization procedures?
- Website is useful and easy to navigate?

Contract Performance

- Provider relations is accessible and knowledgeable and follows up
- Prior Authorization procedures are reasonable and not overbearing or difficult for providers to perform
- The payer is not unreasonable with what they regard as a clean claim

Rental PPO Contract Performance

- Are service lines divisible?
  - i.e. bundled health plan, work comp or auto
- Does the PPO contract with other PPOs?
- Is the PPO's logo on health plan cards and clearly on Explanation of Payments?

Don’t be afraid to just say No!

- Alignetwork
- Care IQ (Corvel PPO)
- Coalition America PPO
- Coventry/First Health Work Comp
- Focus Healthcare Management
- Health Payers Organization (HPO Net)
- Heartland Therapy Network
- MedRisk PPO
- National Health Quest (NHQ PPO)
- National Preferred Provider Network (NPPN) – MedAdvant Healthcare Solutions
- Prime Health Services PPO
- POMCO Group PPC
- Tech Health PPO
- TheraMatrix PPO
- Universal Smart Comp PPO

Locum tenens vs. new providers?

- Locum Tenens - “in the shoes of” providers filling in for credentialed and contracted providers
- Billing policies
- Q6 modifier
- Contracted provider Box 31 or the temp’s name in Box 31

Forecast: Know The Contracting Climate

"Everybody talks about the weather, but nobody does anything about it."
Will Rogers, Humorist

"Weather forecast for tonight: dark."
George Carlin

- Expect significant changes
- Expect pressure to lower payments
- Expect provider profiling
- Expect technology based quality and utilization management systems
- Expect market consolidation

Managed Care 2.0 Summary?

- Expect consumer decision making
  - More companies offer HSAs
- Expect more accountability to patients through high deductible HSA accounts
- Expect more Pay for Performance (P4P)
- Expect more evidence-based treatment models

The Triple Aim Models of Care – Goals

- Lower Cost of Per Capita Care
- Better Outcomes and Better Patient Experience
- Better Population Health

- Reduce Variation
- Reduce Errors and Duplication
- Measure Outcomes
- Limit Care to What's Effective
- Measure Patient Satisfaction

The Implications for the Future Practice Model

- Working at the full extent licensure
  - Evaluate, set plan of care to achieve outcome
  - Use of PTAs, Aides, Physical Plant and Equipment?
- Measure outcomes and be paid by outcome?

Managing an Episode of Care

- "Patient Shared Decision Making"
- Frequent Outcome Assessments
  - Initial
  - Interims
  - Discharge
- Peer Reviews
- Visit Modulation (frequency)
- Episodic Payment
  - Outcome Goal within Duration of Care

Thank You!

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