Managed Care Contract Negotiations

Tips and Tools from the Industry

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MANAGED CARE PAYORS

Definition

• Any form of health plan that initiates selective contracting among providers, employers and/or insurers to channel employees/patients to a specified set of cost effective providers

• These providers have procedures in place to assure that only medically necessary and appropriate use of health care services occurs
REALITY

• Networks

• Rules
### The good intentions of Managed Care

<table>
<thead>
<tr>
<th>Provider access/choice</th>
<th>Traditional/Indemnity</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider access/choice</td>
<td>Unlimited</td>
<td>Restricted to specified network of providers</td>
</tr>
<tr>
<td>Coverage</td>
<td>Focus: Episodic care; major medical</td>
<td>Focus: Prevention, wellness as well as illness</td>
</tr>
<tr>
<td>Out of pocket expense</td>
<td>Deductibles, coinsurance</td>
<td>Minimal co-payment</td>
</tr>
<tr>
<td>Premium cost</td>
<td>Based on Deductible</td>
<td>Low</td>
</tr>
<tr>
<td>Payor/provider involvement</td>
<td>Minimal</td>
<td>High, very structured</td>
</tr>
</tbody>
</table>
Consumer-Driven Healthcare

• Lower premium for affordability
  - High-Deductibles
  - Co-insurance
  - Savings accounts
  - Tax implications

• Blurring lines between indemnity and managed care
Contracting
Contracting and Payor Relations

• “Managed Care” a misnomer
• It is a Relationship
  - Communication
    • Set Expectations
    • Own it!
CONTRACT MANAGEMENT

• Steerage of volume to achieve discounts
• Contracted providers accept discounts or fixed pre-paid amounts for services
• Enrolled patients channeled to those physicians and facilities
• Volume = Discount        Remember this!
TYPES OF CONTRACTS

- **Fee-for-Service (FFS):** Payors pay claims per the fee schedules or billed charges for services
  - **Proprietary:** Payor creates/owns fee schedule
  - **Medicare:** RBRVS
    - Percentage multipliers, conversion factors
    - Specific or current year
- **Per Diems:** Payors pay facility claims based on the number of days services are delivered
  - **Examples:** Medical, surgical, telemetry, SNF
  - Payors also pay based on hours or visits
TYPES OF CONTRACTS

• **Per Case:** Payors pay based on a single price for the completion of a case
  - Examples
    - DRG: Medicare and others pay based on care delivered to resolve a diagnosis
    - O/P surgery: Payors have single, flat rate for all O/P surgeries, or put in groups for predictable cost.
    - Carve-outs

• **Capitation:** Providers of care accept a per member per month (PM/PM) amount to provide defined covered services to a group of eligible members. Examples include:
  - Physicians accept $18 PM/PM for basic primary care services defined by CPT-4 codes
  - Hospital accepts $58 PM/PM for hospital services
FEE-FOR-SERVICE

It is extremely rare to find any “managed care” contracts that pay 100% fee-for-service

WFMC
CASE RATES / DRG

• All inclusive rate for episode of care
• Normally requires "partnership" between physicians and facility
• Example: Coronary Artery Bypass graft (CABG)
  - $30,000 Case rate total
  - $20,000 Hospital
  - $10,000 Physician – includes any consults, assists needed while inpatient
CAPITATION

- Mercy Care Plan 1985
- IPA Arizona 1990
- Scottsdale PHO 1994
- Banner PHO
LEVELS OF FINANCIAL RISK

Incentives

Degree of Risk

Low
Fee-for-Service (FFS)
Discounted Fee-for-Service (DFFS)
Per Diems
Per Case (DRG)
Capitation & Percent of Premium

High

Provider Incentives:

- More ancillaries
- More days
- More cases
- More ancillaries
- More days
- More cases
- Less ancillaries
- Less days
- Less cases
- Less ancillaries
- Less days
- Less cases
What’s a PPO?

- **Organization** that manages contracts with providers for discounts in exchange for “in-network status”

- **Benefit Design** that encourages utilization of contracted providers
Network Configuration

*Health Maintenance Organization (HMO)*

- **HMO Provider Network**
  - Members are considered “in-network” and are only responsible for co-pays
  - **Primary network**

- **All Other Providers**

- Members are considered “out-of-network” and often have no benefits except ER
- Also known as gatekeeper “lock-in HMO”
- Use discount fee & capitated contracting methods
- **Secondary networks** used for out of network ER utilization
Network Options for Payors

**HMO with Point-of-Service (POS)**

**HMO Provider Network**
Members are considered “in-network” and are only responsible for co-pays

**Primary Network**

**All Other Providers**

- Members have lesser benefits but are able to select any provider (point-of-service)
- Members may be responsible for significant balances

**Note:**
- Members pay an additional premium for the right to seek care from out-of-network providers
- **Secondary Networks** provide discount for OON claims
Network Options for Payors
**Preferred Provider Organization (PPO)**

- **PPO Provider Network**
  - Members are considered “in-network” and receive the best benefit level
  - **Primary Network**

- **All Other Providers**
  - Members are considered “out-of-network” and receive reduced benefits

**Note:**
- In-network and out-of-network PPO members are responsible for coinsurance, and deductibles.
- Out of network claims **secondary network** discounts apply
Network Options for Payors

Exclusive Provider Organization (EPO)

- The EPO network has fewer providers but offers members the best benefit level.
- PPO providers are still in-network but members have larger out-of-pocket expenses.
- Members who go outside the EPO or the PPO network receive reduced benefits but Secondary networks could apply.

EPO Provider Network
Members are considered “in-network” and receive the best benefit level

Primary Network

PPO Provider Network

All Other Providers
## Network Options for Payors

### Examples of claim handling

<table>
<thead>
<tr>
<th></th>
<th>In network 1'</th>
<th>Non network 1'</th>
<th>Non network 1'</th>
<th>Pure OON</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In network 2'</td>
<td>in network 2' OON</td>
<td></td>
<td>no contract</td>
</tr>
<tr>
<td>Billed charge</td>
<td>$300</td>
<td>$300</td>
<td>$300</td>
<td>$300</td>
</tr>
<tr>
<td>Contract</td>
<td>$200</td>
<td>$150</td>
<td>$150</td>
<td>none</td>
</tr>
<tr>
<td>Adjustment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allowed</td>
<td>$100</td>
<td>$150</td>
<td>$150</td>
<td>$80 (80% ucr)</td>
</tr>
<tr>
<td>Pt co-pay</td>
<td>$20</td>
<td>$30 (80%)</td>
<td>$60 (40%)</td>
<td>$220</td>
</tr>
<tr>
<td>Payer pays</td>
<td>$80</td>
<td>$120</td>
<td>$90</td>
<td>$100</td>
</tr>
<tr>
<td>Net to provider</td>
<td>$100</td>
<td>$150</td>
<td>$150</td>
<td>$300*</td>
</tr>
</tbody>
</table>
Network Options for Payors
*Local, Regional, and National Networks*

- **Rent carrier networks**
  - Great discounts
  - High rental fees
  - Use only approved TPA’s or Carrier Administration

- **Rent local or regional PPO networks**
  - Good discounts
  - Low rental fees
  - Requires wrap network to handle out of area claims

- **Rent national PPO networks**
  - Good Discounts
  - Moderate rental fees
  - No wrap required
Payer discount paradigm

Large Payer Gains market share thru leverage

Employer Group leaves Small Payer and PPO for better Savings

Large payor negotiates best in class discount

Small payors & PPOs are less competitive

Providers lose revenue and must shift burden to smaller payors
Secondary Business

- Logo, contacted discount, in-network benefits (e.g. person out of state)
- Logo, contracted discount, out of network benefits
- No logo, contracted discount, out of network discount shows on EOB
- ID Cards
Take Aways:

- Get Benefit Information
- Understand the relationship of a secondary network
- Ask for Logo on card to get discount
- Ask for in-network status whenever discount applies
- Ask for split rate
  - Primary-same as big carrier
  - Secondary-Percentage of billed
CONTRACTED PAYOR

IMPROVEMENT PROGRAM
Contracted Payor Improvement Program

- Understand Payor Mix
- Create Payor Report Card
  - Volume
  - Service
  - Relationship
- Create Contract Summary Form
- Create Contract Term Table
Payor Report Card

- Volume
- Service
- Relationship
Volume

- Number of Members/Covered Lives
- Gross Billed charges (consistency across payors)
- % of applicable Payor category
Service
Financial, Administrative

- Denial Rate
- DAR
- First Pass Pay rate
- Phone/website assistance
- Patient portion rate
- Lost claims
Relationship

- Medical Policy
- Contract Simplicity
- Contract Mutuality
- Representative
  - Availability, skill, authority
Payor Report Card

- Objective, data driven
- Volume and Service measurements are very easy to measure
- Create scale for more subjective Relationship measures
  - Rank 1-10
  - Survey staff
Rate Your Payors

![Bar chart showing Volume, Service, and Relationship ratings for Payor A, Payor B, and Payor C. Payor A has the highest volume rating.]
Wouldn’t It Be Nice?

- Create level playing field where payors are rewarded for all three components
- Start with “standard” rate and adjust based on performance
- Understand leverage, market position, current terms
  - Just Sayin
Contract Summary Form

- Create one for each agreement
- Summarize key components of agreement
- Keep one in contract file
- Keep one in a shared drive
- Keep it updated
Term Table

• Create spreadsheet with key information, contract terms for all payors
• Benchmark reimbursement
  - % gross billed charges
  - Specific year RBRVS %
  - Termination dates
CONTRACTING

- Determine your needs/Leverage
  - Increase patient volume
  - Maintain relationships
  - Improve Revenue

- Weigh benefits vs. risks
  - Increase patient volume – lower net reimbursements
  - Keep existing patients – lower net revenue

- New Plan vs. Existing Plan
Leverage

- Geography
- Specialty
- Unique services?
- Referring providers
- Reality check
CONTRACTING

Negotiation Outline

• Read the contract!
• Redline the contract – *Use Track Changes*
• Standardize format for easy comparison
• Read it again!
CONTRACTING
Negotiation Outline

• **Ask questions**
  - Enrollment/demographics. **ID cards**, etc.
  - Rates. What is reimbursement based on? Get fee schedule
  - Get samples of reimbursements. Top thirty +/- codes
  - Turn-around time, Interest, penalties, State law at a minimum
  - Utilization review. Phone/Web authorization, limits, denials, etc.
  - Provider panel. Ask for listing – call references
  - Mutuality. Indemnification, insurance, terminations
  - Provider relations. Single contact for problem solving
CONTRACTING

Negotiation Outline

• Be prepared
  - Establish written agenda
  - Establish ranges of settlement before meeting
  - Reveal Plan weaknesses. Offer proof
CONTRACTING
Negotiation Outline

• **Bargain/negotiate**
  - Use minor contract changes for bargaining
  - Be careful with *shall, must, good, etc.*
    - Prefer *may, use best efforts, acceptable standards, etc.*
  - You never know until you ask
MANAGED CARE CONTRACTS

Negotiation Outline

• **Follow-up**
  - In writing
  - Complete all necessary paperwork
    - Double check
  - Request in-service/training session
Other Issues

- Non-covered services – waiver rules
- Consumer-Directed Health plans
- Patient Responsibility – getting bigger
- Eligibility checks
- Pre-certification
- Prior Authorization
- ID cards
Process

- Plan Identification
- ID Card
- Eligibility Verification
- Co-Pay Collection
- Pre-certification
- COMMUNICATION=Patient Satisfaction
Why Eligibility Verification Matters

- Ripple Effect
  - Erroneous Plan Billing, timely filing
  - Failure to ID OON patients
  - Benefit issues, pre-cert, pre-auth
  - Patient financial responsibilities
  - Patient Satisfaction
Contracting “Best Practices”

- Set Expectations
- Build relationship
- Test Reimbursement Methodology
- Include outlier/stop-loss as applicable
- Include escalators
More Best Practices

- Set turn-around-time for claims payment
- Timely filing 90 days
  - After primary pays - 90 more days
- Penalty for late payment
  - Lose discount
  - Interest
  - Don’t give away state mandated rules!
More Best Practices

• Schedule In-service with Plan
• Train staff in Managed Care in general and contracts specifically
• Address issues. Silence is consent!
Questions and Answers

Thank you…

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