Lesson 7 - MANAGED CARE

For the umpteenth time, the lifeblood of every practice is third party reimbursement. Managed care is now an integral part of the collage that is on the payment side. Participating with such organizations poses fundamental questions a practice has to decide. The managed care contract and oversight is deserving of careful attention. Providers and management must be cognizant of managed care contract provisions sufficient to assess the potential value and then decide whether participation is feasible or not.

What is managed health care?

It’s a system that controls the financing and delivery of health services to members who are enrolled in a specific type of healthcare plan.

The goals of managed health care are to ensure that:

- providers deliver high-quality care in an environment that manages or controls costs.
- care delivered is medically necessary and appropriate for the patient’s condition.
- care is rendered by the most appropriate provider.
- care is rendered in the most appropriate, least-restrictive setting.

What are the major types of managed care plans (MCOs)?

- Health Maintenance Organizations (HMO)
- Preferred Provider Organizations (PPO)
- Point-of-Service (POS) plans

Each of these systems has distinctive features or characteristics.

Health Maintenance Organizations (HMO)

- An HMO enters into contractual arrangements with healthcare providers (e.g., physicians, hospitals and other healthcare professionals) who together form a “provider network.” In simple terms, a contracted provider is one who provides services to health plan members at discounted rates in exchange for receiving health plan referrals.
- Members are required to see only providers within this network to have their healthcare paid for by the HMO. If the member receives care from a provider who isn’t in the network, the HMO won’t pay for care unless it was pre-authorized by the HMO or deemed an emergency.
- Members select a Primary Care Physician (PCP), often called a “gatekeeper,” who provides, arranges, coordinates and authorizes all aspects of the member’s health care. PCPs are usually family doctors, internal medicine doctors, general practitioners and obstetricians/gynecologists.
Members can only see a specialist (e.g., cardiologist, dermatologist, rheumatologist) if this is authorized by the PCP. If the member sees a specialist without a referral, the HMO won’t pay for the care.

HMOs are the most restrictive type of health plan because they give members the least choice in selecting a health care provider. However, HMOs typically provide members with a greater range of health benefits for the lowest out-of-pocket expenses, such as either no or a very low copayment (the amount of money a member is required to pay the provider in addition to what the HMO pays). It (copayment) often must be paid prior to services being rendered.

Preferred Provider Organizations (PPO)

- PPOs are similar to HMOs in that they enter into contractual arrangements with healthcare providers (e.g., physicians, hospitals and other healthcare professionals) who together form a “provider network.”
- Unlike an HMO, members don’t have a PCP (“gatekeeper”) nor do they have to use an in-network provider for their care. However, PPOs offer members “richer” benefits as financial incentives to use network providers. The incentives may include lower deductibles, lower co-payments and higher reimbursemences. For example, if an in-network family physician is seen for a routine visit, the member may only have a small co-payment or deductible. If a non-network family physician is seen for a routine visit, the member may have to pay as much as 50 percent of the total bill.
- PPO members typically don’t have to get a referral to see a specialist. However, as mentioned above, financial incentives are employed to use a specialist on the PPO’s provider network.
- PPOs are less restrictive than HMOs in the choice of health care provider. However, they tend to require greater "out-of-pocket" payments from the members.

Point-Of-Service Plans (POS)

- A POS plan is often called an HMO/PPO hybrid or an “open-ended” HMO. The reason it’s called “point-of-service” is that members choose which option – HMO or PPO – they will use each time they seek health care.
- Like an HMO and a PPO, a POS plan has a contracted provider network.
- POS plans encourage, but don’t require, members to choose a primary care physician (PCP). As in a traditional HMO, the PCP acts as a “gatekeeper” when making referrals. Members who choose not to use their PCPs for referrals (but still seek care from an in-network provider) still receive benefits but will pay higher copays and/or deductibles than members who use their PCPs.
- POS members also may opt to visit an out-of-network provider at their discretion. If so, a member copays, and coinsurance and deductibles are substantially higher.
- POS plans are becoming more popular because they offer more flexibility and freedom of choice than standard HMOs.
Capitation

Traditionally, providers use itemized fee-for-service billing techniques. In capitation, the practice collects only a copay. A capitated plan typically pays a flat or “capitated” fee regardless of whether a patient is even seen. The fee paid covers a certain allowance of procedures, such as office visits. The practice must provide this utilization data to the payer.

Since capitated plans are designed to reduce costs, many variables are considered when dealing with them. Some prepaid plans require the patient obtain authorization prior to a referral and others do not. The requirements vary and are therefore complex to manage.

Historically, fewer than half (46% at the time of this manual preparation) of all payments made by HMOs to primary care physicians are under capitation arrangements. Capitation among specialists is lower than among primary care providers. Therefore, capitation is probably a small portion of most billing and collections processing, somewhere currently about 9%.

Penalties are often employed and allow withholding funds prior to distribution. Caveats exist for over utilization or excessive referrals.

Practice Determinations

In deciding whether to participate in a plan, the practice should be able to answer these questions:

- What information is available on a given plan?
- How is it updated?
- How are appeals handled?
- Is there a plan service representative?
- Is data available on the proven efficacy of the economics of the contract?

Many providers think that when working through contracts, they have no control over the process or outcome. They often accept whatever the boiler plate terms may be without even reviewing contract specifics. Health care providers have many resources. Legislatures in most states have undertaken a variety of protections in the form of managed care laws to ensure that providers get paid for medically necessary services. Most contracts allow termination if the terms of the contract prove to be unacceptable during its term.

Steps for Review

- Read the Contract

Most managed care and other third party payers sign hundreds of provider contracts. They retain an entire contracting department whose sole job is to negotiate the best deal (for the
payers). Because of this expertise and experience, the contracts have been worked and reworked constantly so that virtually every provision has been through an exhaustive testing process.

Of necessity, state law has likely been carefully incorporated into payer contracts, but hiring a lawyer or a consultant to review the contract makes sense. The specialized knowledge may give the provider additional leverage when negotiating other contract changes as well.

Providers should be sure they understand _all the provisions_. If anything is unclear, the payer should be asked to explain. The explanation may even be requested in writing. The written (or oral response notes) should be retained in the event of any future dispute.

- **Definitions**

Pay attention to how terms used in the contract are defined. Key terms may have a particular significance under state law. Providers should look for the definition of a “clean claim,” “medical necessity,” “emergency services,” to make sure they have a clear point of reference. “Clean claims” may be significant under state statues since many obligate third party payers to pay interest on such claims when they are not paid within a specific time limit. Naturally, what constitutes a “clean claim” may be a considerable point of contention in litigation.

Payers are generally only required to pay for services deemed _medically necessary_. The payer is the arbiter of that “necessity,” so it is critical to know how the payer defines it and that the definition is clearly spelled out in the contract.

_Emergency services_ are defined differently too. Such services may be governed under most state laws. The contract should clearly define it. If the payer interpretation allows them to deny payment based on their definition, providers may not be paid.

- **Preauthorization**

Most HMO (Health Maintenance Organization) models employ a primary care physician as a _gatekeeper_ to control _specialist services_. Such operations are slowly becoming a thing of the past with many managed care provider contracts, but they often do include preauthorization requirements. The payer will not pay for certain specialist, diagnostic and facility services if the services have not been preauthorized. If the contract includes such a provision, the provider should review the process involved to be sure that it is reasonable. Providers should be wary of provisions buried in payer policies which permit the payer to retroactively deny any services that were given verbal prior authorization by the payer’s own personnel.

- **Dispute Resolution**

Providers should carefully review and completely understand how _disputes are resolved_. Many state statutes require providers to go through certain internal processes before seeking redress.
through the insurance division or the courts. State courts may be less responsive to claims against a payer where the provider failed to go through the mandated written contract process prior to taking a payer to court. It is also a useful tool for resolving routine and minor payment issues. When a payer overpays a claim, most then offset the overpaid amount against future payments to the provider. The provider is at the mercy of the process even if there is a “proper” disagreement. Providers should attempt to include in the contract provisions prohibiting the payer from offsetting disputed overpayments until the dispute is resolved through a formal resolution process.

- **Performance Monitoring**

When the contract is signed, the provider’s responsibility is to make sure the payer abides by the contract. Often providers fail to request a copy of the contract. Each contract should be filed where it may be easily found for quick reference. Creating three-ring binders for each such contract for ready reference for both providers and the billing personnel is a good practice.

Providers’ staff should keep detailed records when communicating to the payer on the claims process, “paid,” “denied,” etc. Communications should be requested in writing, formal, facsimile or email, with a paper trail to refer back to in the event of a future dispute. Office personnel should always obtain the names of the representatives with whom they speak, telephone number, extension, and record the date and substance of the communication.

Careful calendaring of the dates contracts terminate or automatically renew should be anticipated and flagged. Prior to the annual renewal, providers should review the claims history with each company, the percentage of the practice volume that is covered under specific contracts, reimbursement levels by percentage, and of course, by payment. Then the provider has the information needed to decide whether or not to renew or renegotiate.

**Questions to Consider Before Signing**

1. **How important is this contact to the practice?**
   - What does the contract mean in terms of revenue and expenses?
   - Would it be possible to replace any patients and/or revenue that might be lost?
   - What are the alternatives to this contract?

2. **How does the contract define “medically necessary” care?**
   - Does the contract use an objective standard, such as a “prudent physician” standard, or does it give the managed care organization (MCO) wide flexibility in determining what is medically necessary?
• Does the MCO have a quick and efficient mechanism to determine whether medically necessary services the practice intends to provide a patient are covered under the patient’s benefit plan?
• Is this clearly spelled-out in the contract or a policy manual?
• Does the MCO stand by this information or does it reserve the right to reverse itself?

3. How does the MCO verify that a patient is enrolled in a plan?

• When a patient comes into the office is there a quick and efficient mechanism to verify that the patient is covered by the MCO and to determine whether the patient is an enrollee covered by an MCO plan (e.g., telephone line or Web site)?
• Is this availability/process clearly spelled-out in the contract or a policy manual?
• Does the MCO stand by this information or does it reserve the right to reverse itself?

4. Does the contract (or administrative manual) clearly designate any and all services and procedures that are subject to prior authorization requirements?

• If not, provider should insist on getting this information in writing.
• Does the MCO provide for an efficient and reliable mechanism to obtain prior authorization, which is available 24 hours a day/seven days a week?

5. What is your reimbursement under this contract?

• Does the contract provide enough information to determine what will be paid for the services the practice provides?
• Does it include a comprehensive fee schedule? If not, insist that the MCO provide fee schedules for the practice’s 20-50 most commonly billed procedures. Also, insist that the MCO provide detailed information on payment methodology, including recognition of CPT codes and guidelines. MCO reimbursement policies should be transparent enough to help make a determination of potential reimbursement under the contract.

6. Is reimbursement adequate?

• What are the anticipated costs to provide the services required under the contract? While this is not an easy determination, the practice should have a general idea of the overhead and other expenses associated with running the practice and should be able to juxtapose that information.
• If the contract does not compensate adequately, the practice may actually lose money on the contract.

7. What rights does the contract provide to appeal a reimbursement decision?
- Does the contract provide specific procedures to appeal a reimbursement decision? If the contract refers to administrative policies and procedures, review these procedures specifically to determine appeal rights.
- Is the appeals process fair or is it weighted heavily in favor of the MCO?
- Is there any independent review permitted as part of the internal appeals procedure?

8. Can the MCO change reimbursement terms unilaterally?

- If so, does the contract require the MCO to provide notice of any reimbursement policy changes?
- Is there a mechanism to terminate the contract if policy changes occur that affect the significant other terms of the contract?

9. Does the MCO have an obligation to pay promptly?

- Does the contract include a specific payment time frame, and does the MCO agree to pay interest if it delays payment beyond that time period? Many states have laws that require prompt payment of claims.
- If the state has a prompt pay law or fair business practice act, does the contract comply with the time frames and interest penalties and other claims processing and payment provisions?

To determine whether the state the practice is located in has a prompt payment law, go to

www.ama-assn.org/go/psa

10. Does the contract give the MCO the right to unilaterally “offset” alleged “overpayments” from amounts otherwise due?

- If so, does the contract require the MCO to explain such offsets to the provider?
- Is there a mechanism for the provider to appeal offsets? Does the contract limit the time frame for such payment offsets?
- Many MCO’s conduct retrospective audits of practices several years after services are rendered and then either demand return of sums allegedly “overpaid” or automatically deduct payment without explanation.

11. Product participation

- Does the contract allow selection of which products a practice may choose to participate in, or does it require participation in “all products”?
- Does the contract allow termination in one product or does termination in one product automatically terminate participation in all products?
12. Does the contract require compliance with a prescription drug formulary?

If so, what flexibility exists if the practice goes off-formulary when medical judgment dictates a non-formulary drug?

13. Does the contract allow the MCO to “rent” the practice to other entities?

This relates to so-called “silent PPOs” where a provider signs a discounted fee-for-service contract with an MCO and then without informing the provider, the MCO “sells” or “rents” its provider network to a separate third party, such as a third party administrator. That third party gets the advantage of whatever discount the MCO has negotiated with the provider. Broad definitions of the term “payer” or “participating entities” are signals that the contract may permit this type of activity. Clarify this with the MCO.

14. How is the contract terminated?

- What are the provisions for termination if the MCO breaches the contract?
- Does the contract renew annually or is it an “evergreen” contract, which means the contract automatically renews every year? If it is an “evergreen” contract, what provisions exist for termination for cause or otherwise?
- Is the MCO obligated to provide notice of the practice rights to terminate every year?
- Does the provider have to meet provisions that require an inordinately long period of time in advance of a renewal to meet the request for termination requirements?

Landmark legislation on the Health Care Bill passed in 2010.

The vote in the House of Representatives is over, but a key debate about the new health care bill remains: Will it cut America's medical bill? After more than a year of heated debate, backroom maneuvers, and pitched partisan wrangling, President Obama stands on the verge of enacting comprehensive reform of the American healthcare system.

The House Democrats' passage of reform legislation Sunday night means Mr. Obama will have succeeded where presidents going back decades before him have failed, setting the stage for the biggest expansion of the American social safety net in nearly 50 years.

Here’s a look at the pros and cons of how the reforms might affect the pocketbooks of Americans as taxpayers and as health care consumers.

By the broadest measure – the overall amount of money America spends on health care – the reforms will result in only a minor change compared with the rise that's expected to happen anyway, according to some official forecasts.

That's good, say the backers of reform. It shows that more than 30 million Americans can get health insurance by that year without adding to federal budget deficits.
But to critics, that's bad. It shows that the reforms won't fundamentally change the runaway pace of US health spending – including both public- and private-sector dollars.

With or without reform, the overall US medical bill will account for about 21 percent of gross domestic product in 2019, or 3 percentage points higher than today, according to a recent analysis done within the Health and Human Services Department.

**Pro: Reform will push costs down**

Backers of health care reform say it will expand insurance coverage to more Americans while also tightening the reins on medical inflation. A Congressional Budget Office (CBO) report on Saturday, just before the bill passed, said the measure will insure 32 million more people in 2019.

The expansion of coverage would cost the government an extra $172 billion in that year, the CBO says, or about $5,375 per person newly insured. Most of that spending is the result of a boost in eligibility for Medicaid or of subsidies to help families comply with a new mandate to buy insurance coverage if they don't have it.

Supporters say the expanded coverage is a bargain if you consider the reform's wider framework, including curbs on the growth of Medicare spending. In 2019, when the law's key provisions have taken full effect, the nation's overall spending on health care will be just $25 billion more than if no health care bill had been passed.

In effect, the plan would be covering many more people at about the same price: $4.7 trillion in that year. That estimate comes from Richard Foster, chief actuary for the Centers for Medicare and Medicaid Services.

President Obama and congressional Democrats planned their package to be "deficit neutral," with additional federal spending on health care offset by either tax hikes or the Medicare curbs.

So much for government costs. What about individuals and families?

The cost of a given amount of insurance coverage could fall by 10 to 30 percent due to the reforms, for people who don't have employer-sponsored coverage.

Mr. Foster's analysis, meanwhile, saw no big change in the out-of-pocket costs that families pay on top of insurance premiums, compared with what they'd be paying without the law.

**Con: Reform won't cut costs**

President Obama's critics say his plan will follow a familiar pattern seen since the introduction of Medicare in the 1960s: *Extend a new entitlement without clear cost-control mechanisms and the result will be that spending exceeds expectations.*
In this case, "entitlement" may not be quite the right word. But the government will be expanding Medicaid to millions of families just above the poverty line, and extending subsidies to help millions more comply with the mandate to buy insurance.

Even neutral observers have raised questions about whether Obama's planned Medicare savings – vital to keeping his plan deficit-neutral – will materialize.

Reform proponents have cited the CBO (Congressional Budget Office) analysis as evidence that the reforms will bring federal budget deficits down substantially in the decade beginning in 2020, for example. But CBO itself is careful to qualify its forecast.

"It is unclear whether such a reduction in the growth rate of [Medicare] spending could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or through reductions in access to care or the quality of care," the agency says in its report.

Foster, the Medicare actuary offers a similar dose of skepticism in his analysis. He says the planned squeeze in federal payments may prompt many hospitals to drop out of the program. "Simulations by the Office of the Actuary suggest that roughly 20 percent of [Medicare] Part A providers would become unprofitable within the 10-year projection period as a result of the productivity adjustments," Foster wrote in January 2010.

Another big uncertainty is how many employers will choose to pay a penalty rather than offer insurance as an employee benefit. The more firms that do that, the more people will be looking to the government to subsidize care purchased on a new insurance exchange.

It will certainly provide an interesting experience to participate in the healthcare reform process in the next decade.

**Conclusion:**

No matter what the source is or may become, revenue and its collection are the life blood of the practice. In managed care options, to anticipate a larger volume of clientele may have promise, but the ability to calculate the actual cost of participating in that volume is obvious. The questions and benchmarks provided should assist with participatory determinations. Careful observation of the reform process and its impact on the practice will require attention and monitoring.
ASSIGNMENT

Visit the following web sites and note the information that is available for future reference:

Medline Plus

Kaiser Family Foundation Consumers Union
Take a look at this article:
Consumer Guide to Handling Disputes with Your Employer or Private Health Plan, 2005 Update
(Henry J. Kaiser Family Foundation)

The Managed Care Information Center
See what is available at http://www.themcic.com/

Department of Health and Human Services

American Medical News
Read the article “State medical society lawsuits now target insurance contract provisions.”