Business Institute Program:

"Negotiating Insurance Contracts for Optimum Reimbursement to Decrease Patient Out of Pocket Expenses"

Texas Speech-Language-Hearing Association
Houston, Texas
March 4th, 2011

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Agenda

- A review of Managed Care in today's market
- Common Managed Care Contract terms
- Successful Managed Care Negotiation Strategies
- Contract Performance Monitoring
- Renegotiation considerations at renewal time

A review of Managed Care in today's market

- What are the insurance models?
- HMO – Health Maintenance Organizations
- PPO – Preferred Provider Organization

- The difference between an HMO and a PPO plan,
  - The subscriber must select a primary care physician (i.e. a family doctor or internal medicine doctor) when signing up.
  - The patient must always see the primary care physician (PCP) and receive a referral before going to specialist.
  - Therefore, one specific doctor is in charge of your health care ("Managing your health care") and will be aware and knowledgeable of all the treatment given to you
  - HMOs tend to be a little less expensive in premium rates for the patient
  - Usually pay 100% of preventive benefits

A review of Managed Care in today's market

What about the other payer models?

- IPA – Independent Provider Association
- TPA – Third Party Administration
- MSO/ASO – Management/ Administrative Service Organization
  - Usually associated with self-funded groups, this is when an insurance company, HMO, or third-party administrator provides claims-processing services, but the employer pays the claim costs.
  - Administrative services usually include billing, enrollment, coordination of benefits, payment check processing, subrogation, fraud investigation, and network rental.
- EPO – Exclusive Provider Organization
- ACO [New] Accountable Care Organization

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A review of Managed Care in today's market

What about the other payer models?

Indemnity

An insurance program in which members are reimbursed for covered medical expenses.

This term refers to insurance plans that include little or no managed care components and simply pay a portion of medical bills incurred by the member.

This is a dying model of healthcare insurance….

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Common Managed Care Contract terms

Reimbursement

- **Balance billing**: The practice of billing a patient for the amount remaining after the insurer payment and co-payment has been made. For example, a physician may charge $100 for an office visit and if the insurance company only reimburses the doctor $85, the patient would be billed the additional balance of $15 by the physician. This practice is usually not allowed under most HMOs, but is dependent on the contractual arrangement between the healthcare provider and the health plan.
- **Disallowance**: This occurs when an insurance company or health plan denies payment for certain benefits. For example, if a claim is submitted for teeth whitening, it may be disallowed because of the cosmetic nature of the procedure.
- **Exclusions**: Specific illnesses, injuries or methods of treatment that aren't covered under an employee benefit plan. An example of this would be a pre-existing condition or a procedure, such as cosmetic surgery, that's not medically necessary.

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Common Managed Care Contract terms

Reimbursement

- **Explanation of benefits (EOB)**: A statement sent to covered individuals by a health plan explaining the services provided, the amount billed and the level of payment by the health plan.
- **Medical necessity**: The evaluation of medical services to determine if they're: 1) medically necessary and appropriate to meet basic health needs, 2) consistent with the diagnosis, 3) rendered in a cost-effective manner and 4) consistent with national medical practice guidelines.
- **"Reasonable and customary" (R & C)**: This term refers to the most commonly charged or prevailing fees for a health plan in a specific geographic area. Most insurers pay a percentage of the "reasonable and customary" fees, while the insured individual is responsible for paying any amount charged over this "reasonable and customary" fee.

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Common Managed Care Contract terms

When the patient has to help pay for services

- **Beneficiary**: In reference to Medicare, a person who's eligible to receive healthcare benefits.
- **Coordination of benefits (COB)**: Provision regulating payments when a person is covered by more than one healthcare policy. For example, if an employee is covered under a group plan and also under a spouse's plan, the companies will coordinate payment of benefits so that each company pays the correct portion of the charges and doesn't reimburse the claimant for more than the cost of the medical care.
- **Co-payment**: A cost-sharing arrangement in which a covered person pays a specific charge for a specified service. For example, an HMO may have a $10 office co-payment for physician office visits, so the employee pays $10 at each doctor's appointment. This amount is paid at the time services are rendered.

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Common Managed Care Contract terms

When the patient has to help pay for services

- **Cost sharing**: A broad term representing the ways in which a covered member shares in the cost of healthcare services with the health plan. Examples of this include deductibles, co-payments, and coinsurance.
- **Deductible**: Amount that must be paid prior to receiving medical benefits from a health plan. This is most often associated with PPOs and indemnity companies and can vary from $100 to as high as $2,500 or more. Office visit co-payments are usually paid regardless of whether or not the deductible has been met. Usually, the deductible is based on the calendar year.

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Common Managed Care Contract terms

When the patient has to help pay for services:

- **Dependent**: An individual, other than the employee, who's eligible to receive coverage under the employee's healthcare plan. This is usually limited to spouses and children
- system for providing health care in a specific geographic area, 2) a specific set of basic and supplemental health maintenance and treatment services and 3) a voluntarily enrolled group of people.

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Common Managed Care Contract terms

Network access / participation clauses

- **Non-participation provider (non-par)**: A healthcare provider that doesn't have a contract with the health plan as a provider of care.
- **Open access (OA)**: This arrangement allows HMO members to see participating specialists without having to obtain a referral from their primary care physician. These are most often found in IPA-model HMOs and are also referred to as "open panel."
- **Preferred provider**: Physicians, hospitals and other healthcare providers who contract to provide healthcare services to persons covered by a particular health plan. See preferred provider organization (PPO).

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Common Managed Care Contract terms

Network access / participation clauses

- **Open panel**: An HMO that contracts with existing physicians and hospitals, rather than a closed panel, which is made up of salaried healthcare providers.
- **Closed panel**: A type of HMO in which the physicians are employed by the health plan and only see patients who are members of the HMO.

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Common Managed Care Contract terms

Standard Carrier definitions

- **Payer or payor**: A private or public organization that underwrites or pays for healthcare expenses. This usually refers to an insurance company or HMO.
- **Point-of-service plan (POS)**: An HMO or PPO that includes an option allowing members to receive services outside the health plan's provider network. These services are usually provided at a reduced benefit with much greater out-of-pocket costs and different benefit levels, and were created to offer additional flexibility in managed care plans.

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Successful Managed Care Negotiation Strategies

Authorizing treatment

In negotiating contract, look for these provisions:

- ✓ The contract allows the autonomy to provide certain treatment without the payers prior authorization
- ✓ The contract provides clear, easy to follow procedures for obtaining a payer's authorization;
- ✓ Make authorization procedures as consistent as possible with existing procedures followed by the providers' staff; and
- ✓ Provide a simple mechanism for resolving disputes over what treatments are "medically necessary".

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Successful Managed Care Negotiation Strategies

Claims submission and payment

In negotiating contracts, look for these provisions:

- ✓ What documentation must the provider supply to the payer?
- ✓ How may days after services are provided must a claim be submitted for payment?
- ✓ How many days after a claim is accepted as a "clean claim" must the payer submit payment to your office?

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Successful Managed Care Negotiation Strategies

Claims submission and payment
In negotiating contract, look for these provisions:

- ✓ Will interest be added to your payment if the claim is not paid timely by the carrier?
- ✓ What is the procedure for coordination of benefits?
- ✓ Under what circumstances when you may be able to bill the patient?

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Successful Managed Care Negotiation Strategies

Claims submission and payment
In negotiating contract, look for these provisions:

- ✓ Can you be paid a partial payment on claims that are pending a final resolution of any disputed amount?
- ✓ Will you need to submit additional documentation in the event of a dispute?
- ✓ Are you ever subject to any charge backs after you have been paid?

Successful Managed Care Negotiation Strategies

The Term and Termination Contract Considerations:

Determine how long you want to be in the payer's network:

- ✓ Read exactly what the "Initial Term" of the agreement requires.
- ✓ Once the " Initial Term" is met, when does the contract come up for renewal?

How much notice are your required to provide, before they will let you Terminate the agreement?

- ✓ Are there any long term consequences if you choose to terminate your participation with the payer, as in the case of Medicare or Medicaid payer

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Contract Performance Monitoring

How to review your experience with the payer:

Successful implementation of a contract-monitoring program requires that the following activities be undertaken:

- ✓ Reviewing the contract for key dates and performing appropriate follow-up
- ✓ Review the contract for key performance obligations and rights
- ✓ Establish benchmarks you are required to abide by as a participating provider
- ✓ Assign responsibility within your company to monitor each requirement so this can be reported to the payer when re-negotiation with the payer come due.

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Contract Performance Monitoring

How to review your experience with the payer: (Continued..)

- ✓ Track how often the payer was late in claims payment
- ✓ Track how often the payer was late in providing prior authorizations
- ✓ Track how often the payer denies or retro authorizes your authorization requests.
- ✓ Has the payer decreased your rates during the contract term, and did they give Your office notice?
- ✓ Once you have done the above analysis, now you are ready to re-negotiate your agreement

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Renegotiation considerations at renewal time

Ask yourself "Is this contract a good fit for your company?"

o How open are they to payment accurately and timely

o Do they handle your claims appeals in a timely manner?

o Have you been able to meet with the provider relations rep when problems occur?

If you must ***terminate*** the agreement…before you do this

o Develop a cash pay strategy for your clients

o Accept credit cards

o Meet with banks to offer financing for your therapy services.

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Conclusion:

Always strive to diversify your book of revenue, keep on the look out for new Therapy services that will provide market differentiation and consider obtaining Accreditation for your facility or certification for specialized services.

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Initiatives of Managed Care Expansion

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Overview

- Current delivery models
- Geographic Areas and Populations Served
- HHSC Proposals

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Delivery Models

- STAR
  - *Capitated, Health Maintenance Organization (HMO) model for non-disable pregnant women and children.*
  - *Provides acute care services*
- STAR+PLUS
  - *Capatated HMO model for disabled Medicaid clients and dual eligibles (Medicaidand Medicare)*
  - *Provides acute and long term services and supports (LTSS)*
- STAR Health
  - *Capitated, HMO model for foster care children*
  - *Provides acute care services wit emphasis on behavioral health and medication management.*
- Primary Care Case Management (PCCM)
  - *Non-capitated service delivery model*
  - *Includes non-disabled pregnant women, children and disable adults*
  - *Acute care services only*

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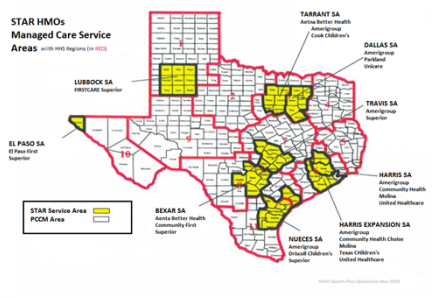

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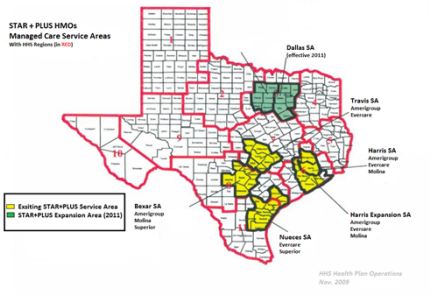

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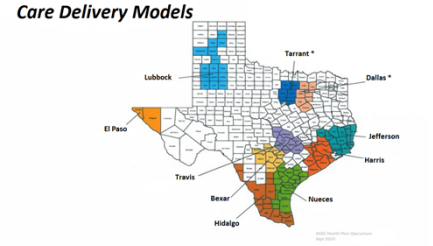
Proposed Geographic Distribution of Managed Care Delivery Models



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2011 Proposed Expansion

- **Bexar Service** (STAR and STAR+PLUS)
  - Bandera
- **Harris Service** (STAR and STAR+PLUS)
  - Austin
  - Wharton
  - Matagorda
- **Jefferson Service** (STAR and STAR+PLUS)
  - Chambers
  - Hardin
  - Jasper
  - Liberty
  - Newton
  - Orange
  - Polk
  - San Jacinto
  - Tyler
  - Walker
- **El Paso Service** (STAR and STAR+PLUS)
  - Hudspeth
- **Lubbock Service** (STAR and STAR+PLUS)
  - Carson
  - Deaf Smith
  - Hutchison
  - Potter
  - Randall
  - Swisher
- **Nueces Service** (STAR and STAR+PLUS)
  - Brooks
  - Goliad
  - Karnes
  - Kennedy
  - Live Oak
- **Travis Service**(STAR and STAR+PLUS)
  - Fayette

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Proposed South Texas Counties

- Cameron *
- Duval
- Hidalgo *
- Jim Hogg
- Maverick *
- McMullen
- Starr
- Webb
- Willacy
- Zapata

** State law currently prohibits use of Medicaid HMOs in these counties*

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HHSC Proposals

- Expand Existing Service Delivery Areas to Contiguous Counties
- Expand STAR+PLUS to Lubbock and El Paso
- Expand STAR and STAR+PLUS to South Texas

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HHSC Proposals

- Expand Existing HMO Service Delivery Areas (SDA) to Contiguous Counties
  - Effective Date: SEPTEMBER 2011
  - Process: Amend existing contracts
  - General revenue impact: ($45.9 million)
- Expand STAR+PLUS to Lubbock and El Paso
  - Effective Date: MARCH 2012
  - Process: Competitive procurement
  - General revenue impact: ($11.2 million)
- Expand STAR and STAR+PLUS to South Texas
  - Effective Date: MARCH 2012
  - Process: Competitive procurement
  - General revenue impact: ($290 million)
- Convert PCCM Areas to STAR Program (164 counties)
  - Effective Date: MARCH 2012
  - Process: Competitive procurement
  - General revenue impact: ($61.2 million)

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HHSC Proposals

November 2010
- Release Draft RFP

December 2010
- Public comment period

February 2011
- Release Final RFP

April 2011
- MCO responses due

May 2011
- Proposal Evaluation

June 2011
- Contract award

July 2011–February 2012
- Implementation

March 2012
- Operations begin

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Contract Discussion

Role Play Question and Answers