

MANAGED CARE

Contracting & Reimbursement

ADVISOR

PPACA will bring major changes for contracts and revenue

The Patient Protection and Affordable Care Act (PPACA) and the Reconciliation Act of 2010 will have significant ramifications for managed care contracts and reimbursement, say experts who have analyzed their many details. Some of the effects may be seen right away and some will trickle down over time as the provisions affecting one part of the healthcare community eventually have consequences for others.

Some implications of PPACA can be predicted already. The sheer scope of the law guarantees that providers will see changes to managed care arrangements, notes **Eric Rackow**, CEO of SeniorBridge, a New York City-based company providing case management services to providers across the country.

“The plan provides millions of Americans with subsidies from the government that will enable them to go to

exchanges to obtain insurance, so that will be through the current insurance industry,” Rackow says. “That will be a huge influx of patients through this system. Secondly, the plan does start to regulate the industry, and that will be reflected in the way contracts are written and the way revenue is provided.”

The health reform law will produce a rapid change in the way healthcare is delivered in the country, he says.

“We will see a shift in the health plans, the hospitals, the industry at large, in how we manage patients,” Rackow says.

“The need for this change has been known for a long time, but practice

tends to follow reimbursement, and there will be some real changes in reimbursement.”

For starters, providers will be pressured to reduce re-hospitalizations through bundled payment legislation (2012 for Medicaid and 2013 for Medicare) and penalties for preventable readmissions (2012). Rackow suspects that health plans will soon follow by requiring the same sort of improvements when contracts are renewed.

“The government is setting up certain standards as the way healthcare providers will be expected to provide cost-efficient, quality care, and managed care entities are going to pick up on that and impose their own version of those same standards,” he says. “Look at what PPACA is doing now with Medicare and Medicaid, and you can see what likely is going to happen with managed care as well.”

“Look at what PPACA is doing now with Medicare and Medicaid, and you can see what likely is going to happen with managed care as well.”

—Eric Rackow

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More bundled payments

PPACA will lead to significant changes in the way managed care companies reimburse providers, Rackow says.

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"I think you will see increased pressure to have bundled payments, to take care of people over a period of time instead of episodically," he says.

Some lawmakers and payers have considered a plan for bundled payments in which, instead of paying a hospital just for the specific hospital admission, they would be paid for the three days before and the 30 days after, Rackow says. So if a patient gets readmitted during that period, there is no additional reimbursement from Medicare or the managed care entity.

"What's going to happen in managed care and Medicare is that they will not pay for readmissions that are unnecessary. They will bundle the payment for the patient, so you have an incentive to coordinate care and make sure that patient doesn't get readmitted unnecessarily,"

he says. "That would be a major change in the way payment is provided."

So what can you do now to prepare for that kind of dramatic change? Rackow says you should start to organize your operation to provide care coordination when the patient is at home in order to prevent that person from being readmitted.

"One way to do that is to use care managers to do care coordination at home, making sure the person understands the medications they're taking, that they're taking the medication, and that they have food and water in the home," he says. "We're going to see a real difference in how we handle patients after they walk out the door, because there will be a strong incentive to keep that patient from coming back to the hospital or the physician practice for additional care."

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Capitation gains more attention

Most of the significant changes won't come immediately, says **Bill Gilbert**, vice president for marketing at Warren, NJ-based AdvantEdge Healthcare Solutions, one of the top 15 medical billing providers in the United States.

Given the nature of the managed care contracting process, most providers will be able to continue with business as usual until it is time to renew a contract or until the first trickle-down effects are seen.

"Plus, everyone is still trying to figure out exactly what is in this reform," Gilbert says. "There's no doubt there are things buried in there that will affect managed

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care contracts and reimbursement rates and that just haven't been realized yet."

Gilbert says his company's analysts are already seeing more pressure on specialists, such as radiologists who are contending with reduced reimbursement from Medicare, and he expects managed care payers to follow suit.

"We do expect to see payers doing more in the near future with capitation," he says. "They are going to start experimenting around the edges with some form of capitation or some new models that incorporate that same idea. The reform bill has a five-state global capitation model demonstration, so if I were a payer, I'd certainly be looking at that and saying, 'The government has that going, so I might try to piggyback.'"

Position yourself for the future

Evidence-based care will be more of a focus as well, Gilbert says, which will eventually result in managed care payments being tied more directly to results in the contract.

"We don't think that will have a big impact in the short term, but over time we are going to see more

contracts that tie reimbursement directly to results," he says. "That is something that we think will have a big impact in the long run."

Gilbert advises providers to look seriously at the underlying themes and patterns in PPACA, such as the move toward evidence-based medicine and the focus on efficiency and cost control, rather than trying to focus only on what will happen right away.

Managed care contracts and reimbursement may see few dramatic effects immediately, but that is not reason to relax, he says. Instead, it is an opportunity to focus on the long term and what may happen the next time a contract is up for renewal.

"Smart practices will think about what those trends mean for their business and try to line themselves up to be in a good position when the payer comes to you and starts demanding more," Gilbert says. "Many of these improvements are not things that can be done overnight, and you can put yourself ahead of the game if you have seen that coming and taken the right steps. The ones who saw the handwriting on the wall and acted sooner

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Acute care hospitals may see some benefit

There could be some good news in the Patient Protection and Affordable Care Act (PPACA) for acute care hospitals, says **Michael Sandnes**, managing director of healthcare at Executive Sounding Board Associates, a Philadelphia-based turnaround consulting company that specializes in health-care providers facing financial difficulty.

Sandnes says there will be winners and losers from the fall-out of PPACA, but acute care hospitals may see greater reimbursement for patients who are now treated as indigent. On the other hand, long-term care providers most likely will see their reimbursement rates cut as a result of the reform, he says.

"Managed care will continue to struggle because, whether you're using a capitation model or a purely negotiated contract model, the system is not going to be set up like that in the future," Sandnes says. "As this 3,000 pages of health-care reform goes into effect, the provider who is greatly

dependent on managed care contracts is going to continue to suffer more."

Managed care payers are already beginning to introduce more stringent requirements and lower reimbursement rates to prepare for the effects of PPACA, he says, and savvy providers are preparing their best responses for the next round of contract negotiations.

"The providers who are very sophisticated and have done their homework, the ones who know exactly what their break-even point is when they put a patient in the system, they're the ones who are going to come out ahead," Sandnes says. "A lot of hospitals have had to just go with whatever the previous contract agreement was or rely on the payer to do the analysis, but the stakes are much higher now, and you have to be ready to negotiate with good information to back you up."

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will be the ones who are going to be in the very best position at the negotiating table.”

Insurers already responding to changes

Reimbursement rates will be squeezed across the board in the near future because of the looming claims loss ratio rules that will start to phase in by 2014, says **Joel Ohman**,

a certified financial planner in Tampa, FL, and the founder of the website HealthInsuranceProviders.com.

“That’s going to cap a lot of the profit potential for the insurance companies, and that will in turn make them crack down harder in negotiations for different network contracts, and it filters down all across the board,” says Ohman. “Everyone will be pressured.”

Major PPACA components affecting managed care contracts

To determine how the Patient Protection and Affordable Care Act (PPACA) will affect managed care contracts, look to how the reform effort is affecting other parts of the health-care system, says **Bruce Fried, JD**, a partner in the Washington, DC, office of Sonnenschein Nath & Rosenthal, a national law firm focusing on healthcare providers, and the former director of the Center for Health Plans & Providers, part of CMS.

The effects on other healthcare components will eventually alter managed care contracts when taxes and quality demands are passed on, Fried says. “So far, the debate has revolved around the points of difference, not the patterns,” he says.

Despite the long-term reaches of the reform, at least 15 aspects of the bill will become effective this year.

Fried provides this summary of some of the components most likely to affect managed care contracts, either directly or when costs are passed on through the healthcare system:

➤ **Limitation of deduction for remuneration paid by health insurance providers.** An insurance provider is a covered health insurance provider if at least 25% of the insurance provider’s gross premium income is from health insurance plans that meet the minimum credible coverage requirements. No deduction is allowed for remuneration paid to any officer, director, or other worker or service provider that exceeds \$500,000. Exceptions for performance-based remuneration, commissions, or remuneration under existing binding contracts do not apply. The limitation on deductions imposed by PPACA is effective for remuneration paid in taxable years beginning after 2012 with respect to services performed after 2009.

- **Imposition of annual fee on health insurance providers with respect to U.S. health risks.** The annual fee imposed by PPACA on health insurance providers will be apportioned among providers based on market share of net premiums written during the preceding calendar year. The first \$25 million of net premiums are excluded, net premiums between \$25 million and \$50 million are only 50% included, and 100% of net premiums written in excess of \$50 million are taken into account.
- **Imposition of annual fee on branded prescription pharmaceutical manufacturers and importers for sale to specified government programs or pursuant to coverage under any such program.** The annual fee imposed by PPACA on branded prescription pharmaceutical manufacturers and importers will be apportioned among manufacturers and importers based on market share of branded prescription drug or biological product sales taken into account during the previous calendar year. Drugs and biological products eligible for Orphan Drug Tax Credit are excluded for purposes of this calculation. The aggregate annual fee is \$2.5 billion in 2011, \$2.8 billion for 2012 and 2013, \$3 billion for 2014 through 2016, \$4 billion in 2017, \$4.1 billion in 2018, and \$2.8 billion for 2019 and thereafter.
- **2.3% excise tax on medical device manufacturers.** PPACA imposes a 2.3% excise tax on sales by medical device manufacturers, producers, or importers. Eyeglasses, contact lenses, hearing aids, and other medical devices purchased by the general public at retail are excluded from this excise tax. The tax is effective for sales after December 31, 2012.

Some insurance companies are preemptively trying to increase rates to prepare for 2014, Ohman says, and some are reclassifying different types of expenses so that they meet the definition of medical expenses.

"You'll see some hijinks or creative accounting as they prepare for 2014," he says. "That, in turn, is going to put a lot of pressure on whoever is doing the contract negotiations. When it's time to renew a network contract, there's going to be a lot more pressure than in years past because of all the changes. They're not going to wait until 2014 to start squeezing."

Profit margins will be reduced across the board, which will result in tighter contract negotiations, says Ohman. What remains to be seen is exactly how far down the line those tighter margins will have an impact.

"If you're an insurance company and your margins are being squeezed by the feds, you might say you'll pass that on by cutting the commission to your agents. Or you might pay more of a commission to your agents to incentivize them to squeeze the providers more," Ohman explains. "It will be interesting to see the approach different companies take when they come to you for renewal."

It's a certainty, however, that providers will be forced to provide care more efficiently. "Essentially, what the

bill does is create one huge managed care organization, and the backbone is making everything electronic, which should make everything more efficient," Ohman says. "A lot of these smaller players, if they're not prepared to step up to the plate, make the changes they need to, and buckle down at the negotiating table, they could be squeezed a little too hard and who knows what will happen."

To best position yourself for the coming changes, Ohman advises first taking a close look internally to determine how you might make patient care and overall operations more efficient. If there is any room for improvement, that will help you cope with the lower margins, he says.

Also, look for any evidence that your organization already is working efficiently, especially if you can show that you are more efficient than most providers. That can be persuasive when you sit down at the negotiating table for a contract renewal, Ohman says.

"You also can look at aligning yourself with some bigger players to take advantage of some economies of scale," he says. "If you're a smaller player, you could either partner with a bigger player or with several smaller providers and look for ways that would improve your purchasing power." ■

Use leverage to get best P4P language in contracts

When you sit down to negotiate a new managed care contract and the person on the other side of the table starts talking about pay for performance (P4P), what are your options? Do you have to simply accept whatever the other side demands, or can you influence the P4P contract language?

You may have more power than you think, says **Murali Karamchedu**, vice president for healthcare architecture at Portico, a medical consulting company based in Blue Bell, PA. The smallest hospitals and physician practices may not have the power to greatly influence the contract language, but others can shape the P4P components

to their advantage or at least avoid the traps that can make the plans detrimental, Karamchedu says.

Karamchedu notes that hospitals and physicians sometimes are hesitant to question the contract language that is offered. They often find the P4P plan attractive because it promises increased revenue in return for meeting certain standards in patient care and administration. But he cautions that the contract language can make the picture rosier than it really is.

"There is quite a bit of murkiness in how the programs work. They can be presented to the provider in

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P4P*< continued from p. 5*

the best terms, and everyone looks at how well the pilot programs worked as evidence that it will work well now," Karamchedu says. "But the pilot programs were done by people who were highly motivated to make them successful. When we try to operationalize these things, the existing systems are disconnected and the administrative management for the P4P bonuses can be a challenge for providers."

He advises studying the contract language with these questions in mind:

- **Is there a cap in the bonus structure?** If there is a cap, how does it apply? Does it seem high enough to make seeking the bonus worthwhile?
- **Will the health plan provide tools or support to meet these goals?** Ambitious goals may seem more achievable if the company is providing software, training, or other aid. Always consider whether you are simply being told to achieve a goal and it's up to you to decide how, or whether you're being invited to participate in a quality improvement project with others.
- **How will you prove your compliance?** The documentation necessary to show that you have reached the goals required for the bonus could be burdensome, particularly if the effort will be ongoing and you will have to prove compliance at regular intervals. Consider whether the documentation will create new administrative tasks and how that work will be absorbed into your organization. How often will you have to submit proof? In what form must the information be submitted?
- **Will the program require an electronic medical record (EMR)?** Some P4P plans require that information be submitted as part of an EMR, so you if do not currently have EMRs, you would have to consider the costs of adopting the technology or accelerating your plans to do so.
- **Will the P4P data be handled as part of medical management or case management, or will it be part of routine claims submissions?** The manner in which the data are monitored and maintained can make a difference in how burdensome the effort is for the provider. Can the data, or lack of a data submission, interfere with a claim submission? Will claims be rejected if they do not have the proper P4P data attached? How will the structure of the P4P program affect your revenue stream, regardless of the P4P bonus?

Jordan Battani, a principal researcher at CSC, a technology consulting company based in Falls Church, VA, suggests looking for the following key issues in contract language concerning P4P:

- **Standard measures.** Make sure the bonus plan calls for you to measure performance using criteria and data that are common to the field and already measured for other purposes, rather than a completely new data set that would mean additional work.
- **Enough incentive.** Carefully consider whether the bonus is enough to make the extra work, if any, worthwhile and to motivate the organization and employees. If the bonus is low and the burden is high, you are not likely to comply, and the health plan should hear from you that a contract written that way will not be successful.
- **Pay for improvement.** Some P4P programs require reaching a threshold in performance before any bonus is earned, but others will reward significant improvement from the baseline, particularly if your organization is far below the norm when the program begins. ■

Questions? Comments? Ideas?

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Cost of care tool proves popular

CIGNA is reporting that its Cost of Care Estimator tool is proving quite popular with providers and patients, leading to speculation that other payers may soon offer similar methods for taking the mystery out of determining reimbursement and patient responsibilities up front.

The first year of the tool's use has been a complete success, says **James Nastri**, vice president of e-business at CIGNA, a managed care company based in Bloomfield, CT.

The company piloted the project with a limited number of providers for 15 months before launching the CIGNA Cost of Care Estimator in April 2009, offering a new technology that would inform patients and healthcare professionals of the total cost to be charged for medical services based on the individual's specific CIGNA health plan.

The Estimator's real-time cost estimates detail which portions of the bill are to be paid by the CIGNA health plan and which are to be paid by the covered individuals, whether the costs come out of pocket due to coinsurance or copays, or from their flexible spending accounts, health reimbursement arrangements, or health savings accounts.

By providing itemized cost estimates and explaining the sources of payment, the CIGNA Cost of Care Estimator helps patients understand their benefits and how much they owe for specific services, Nastri says. It also

serves as the basis of pre-care financial discussions in order to help avoid after-the-fact surprises.

Good reports from providers

Unlike other proposed "real-time adjudication" payment systems, the CIGNA Estimator informs the covered individual and healthcare professional of the cost of services and how much will be owed prior to services being delivered. The Estimator facilitates an up-front financial discussion that allows for payment arrangements, anticipating account contributions to pay for services in the future, and discussions around treatment options. The Estimator is designed to be available for all medical services, including high-cost procedures.

The same benefits may be coming soon for other managed care providers. For the past year, CIGNA has been working with America's Health Insurance Plans, the Washington, DC-based national association representing nearly 1,300 companies providing health insurance coverage to more than 200 million Americans, to help standardize transactions between healthcare professionals and insurers. The goal is to streamline and simplify the tasks that providers perform routinely, such as checking benefits and obtaining payment estimates.

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Example of the results for a patient's cost of care estimate

Estimated total cost of service (before CIGNA payment)	\$1,300	This is the total estimate amount as of November 9, 2009, for the services(s) above, based on CIGNA's discount. This includes the amount CIGNA will pay and the amount that will be the patient's responsibility.
Patient deductible responsibility	\$139.15	This amount is calculated based on a yearly maximum deductible of \$150 and the patient's paid-to-date amount of \$10.85 (as of the date of this estimate).
Patient coinsurance responsibility	\$116.09	This amount is determined by subtracting the amount remaining from the estimate after the deductible is met and applying the coinsurance rate.
Patient copay responsibility	\$0	The copay for the healthcare professional or facility, based on plan design.
Estimate of patient total responsibility (before CIGNA payment)	\$255.24	The anticipated amount the patient will owe after plan benefits are applied to the estimated cost. This includes any deductible, coinsurance, or copay. This amount might be lower if the out-of-pocket maximum has been reached.
Anticipated health account payment (for account-based plans only)*	\$50	Based on the money available in the health account(s) as of November 9, 2009, this is the amount that is anticipated to be paid directly to the provider.
Estimate of what patient owes provider	\$205.24	This is the amount the patient will owe after any health account payment.

Source: CIGNA.

Cost of care

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Providers tend to use the Estimator heavily once they adopt the tool, Nastri says. About 70% of the transactions come from the Southeast region and Texas, he says, partly because managed care plans common in those areas tend to be more complex with regard to deductible and copay arrangements.

Web use streamlined

Healthcare professionals can quickly obtain estimates using their existing desktop technology, so medical practices and hospitals need not invest in new technologies to use the CIGNA Estimator.

The itemized cost estimate is generated by the proprietary Thomson Reuters treatment cost calculation tool and backed by its analytic and predictive modeling expertise. About 17,000 of CIGNA's 400,000 providers nationwide are using the Estimator, Nastri says. He expects the number of users to grow steadily.

"We've gotten great feedback from doctors and hospitals using the tool," he says. "We had a target for the first year of 100,000 estimates, and we're well ahead of that goal. It's looking like we will end up with about 150,000 estimates in the first year for doctors and hospitals, handed right to their patients." ■

Estimator can improve payments

CIGNA's Cost of Care Estimator tool is particularly useful when a patient's health insurance plan has changed for some reason, says **James Nastri**, vice president of e-business at the Bloomfield, CT-based managed care company. The patient may have previously understood fixed copays or deductibles, but his or her new plan may be more complex.

"If they have a plan that calls for them to pay a percentage of the bill, or a percentage after a deductible is met, the patient can have no idea going in what they are going to owe," Nastri says. "This tool allows the provider, at the point of admission and when you are checking coverage, to print out an estimate of the service you're about to provide. That estimate

will show what the service costs, how much is covered by the plan, how much will be paid by any accounts the patient may have, and the bottom line of what the patient will owe."

More typically, without the Estimator, the patient leaves the health provider with no real idea of what will be owed and waits for an explanation of benefits from the insurer and a bill from the provider. If the figures on those items match, the patient might be satisfied that the calculation is correct. But if they don't match, or the patient can't understand how they were calculated, payment might be delayed. "Now, with the ability to insert the estimate into the process, they can know with confidence up front what they will need to pay," Nastri says.

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