

Improving Managed Care Contracts and Risks of Out-of-Network Billing

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Improving Managed Care Contracts

Elements of Contracting

- Provides access to patients in exchange for discounts on charges
- Demonstrate the value proposition to the payer
- Understanding what leverage the center has

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- Understand your leverage means:
 - Understanding your Case Mix
 - Understanding your Costs
 - Understanding your Payer Mix
- AND
- Understanding how all of these interrelate and why they are important

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- Types of Managed Care Fee Schedules
 - Discount off charges
 - Percentage of Medicare ASC rates
 - Percentage of Medicare HOPD rate / APC's
 - Case rates
 - Payer's unique groupers (Aetna, United, etc.)
 - Implants, carve-outs and pass-throughs
- Market forces and Managed Care Environment
- Should an ASC choose to be out-of-network

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Case Study 1 Illustrates:

Guidelines and Tools for Assessing Payment Policy and how it Impacts Reimbursement in an ASC Managed Care Contract

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Background Information:

- Ohio Surgicenter (OSC) is located in an urban market and has been contracted with Health Plan America (HPA) for 3 years
- Casemix of Center = GI, ENT, Ophthalmology, Orthopedics, General Surgery
- HPA represents 20% of the business at OSC

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- Where cases are coming from?

<u>Payer</u>	<u>%</u>
• Anthem	28%
• United Healthcare	23%
• HPA	20%
• Medicare	20%
• Other	9%

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HPA Compensation Exhibit A

<u>Payment Group</u>	<u>Rate</u>	
Group 1	125% of Medicare	Non-grouped procedures at 80% of billed charge Prosthetics & Implants at Cost Multiple Procedures at 100/50+++
Group 2	125% of Medicare	
Group 3	125% of Medicare	
Group 4	125% of Medicare	
Group 5	125% of Medicare	
Group 6	125% of Medicare	
Group 7	125% of Medicare	
Group 8	125% of Medicare	
Group 9	125% of Medicare	
Group 10	\$ 500.00	

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Value of the HPA Contract

- Total Revenue \$6,383,772
- Total Case Volume 6,156
- Net Revenue Per Case A \$1,037
- Cost Per Case B \$750
- Operating Income per Case A-B \$287
- Operating Margin (A-B)/A 28%

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Scenario:

A letter from HPA is received by the Business Office several months prior to the end of the year, and it is addressed to "Dear Provider"

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Correspondence

(Envelope Addressed to, Attention: Business Office)

September 15, 2004

Dear Provider:

Congratulations! We are pleased to inform you that we are increasing your payment rates to 135% of Medicare for the HPA payment groups outlined in Exhibit A of your contract effective January 1, 2006. In addition, Group 10 will be increased to \$575.00. Attached, please find the updated groupers for your records and review. Thank you for your participation in the HPA network.

Sincerely,
VP Provider Relations

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March 2005, Six Months Later

- Business Office Representative identifies claims with improper payment
- **Several EOBs are assessed and the following are examples of the findings upon review:**

CPT Code	Old Payment	New Payment	Underpayment Per Case
30520	\$ 788	\$602	(\$186)
49505	\$ 788	\$450	(\$338)
29884	\$1,674	\$689	(\$985)

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Appeals Process:

- An appeals letter is sent to HPA regarding payment errors on the claims
- HPA provides a written response on appeals, indicating that, “all claims were paid in accordance with the contract”.
- The Business Office notifies the Administrator that there is a claims processing problem with HPA and requests assistance with troubleshooting the claim denials

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Administrator Action:

- Administrator requests explanation from HPA Provider Network Representative
- Provider Network Representative states that a letter was sent out dated September 15th with an update to the payment groups effective January 1st
- Business office representative identifies September 15th letter which has been placed in a “Miscellaneous Correspondence” file
- The Administrator had never seen the letter or the updates to the groupers

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The Grouper Shift:

- Administrator reviews the groupers and learns that they are not consistent with Medicare groupers
- The groupers have completely changed for almost every CPT code
- With respect to the EOBs that were appealed, the following demonstrates a few examples of the shift in groupers that were identified when the Administrator compared the new grouper list to the Medicare groups, which is what she believed the contract to follow

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The Grouper Shift:

CPT Code	Medicare <u>Group</u>	HPA <u>Group</u>	Grouper <u>Variance</u>
30520	4	2	(2)
49505	4	1	(3)
29884	9	3	(6)

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What does the New HPA Grouper Methodology Mean to OSC?

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HPA Revenue Analysis				
Grouper Assessment I				
Initial Contract				
Payment Groupers	Volume	Percentage	Rates (1-9 @ 125% of Medicare)	Projected Revenue All procedures
1	670	11%	\$ 416.25	\$ 278,887.50
2	736	12%	\$ 557.50	\$ 410,320.00
3	484	8%	\$ 637.50	\$ 308,550.00
4	506	8%	\$ 787.50	\$ 398,475.00
5	310	5%	\$ 896.25	\$ 277,837.50
6	20	0%	\$ 1,032.50	\$ 20,650.00
7	108	2%	\$ 1,243.75	\$ 134,325.00
8	3138	51%	\$ 1,216.25	\$ 3,816,592.50
9	60	1%	\$ 1,673.75	\$ 100,425.00
10	124	2%	\$ 500.00	\$ 62,000.00
Total	6156	100%		\$ 5,808,062.50
NR / Procedure				\$ 943.48

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HPA Revenue Analysis				
Grouper Assessment II				
Impact due to Change in Groupers				
Payment Groupers	Volume	Percentage	Rates (1-9 at 135% of Medicare)	Projected Revenue All procedures
1	1318	21%	\$ 449.55	\$ 592,506.90
2	384	6%	\$ 602.10	\$ 231,206.40
3	4140	67%	\$ 688.50	\$ 2,850,390.00
4	20	0%	\$ 850.50	\$ 17,010.00
5	150	2%	\$ 967.95	\$ 145,192.50
6	26	0%	\$ 1,115.10	\$ 28,992.60
7	0	0%	\$ 1,343.25	\$ -
8	0	0%	\$ 1,313.55	\$ -
9	8	0%	\$ 1,807.65	\$ 14,461.20
10	110	2%	\$ 575.00	\$ 63,250.00
Total	6156	100%		\$ 3,943,009.60
N/R Procedure				\$ 640.51

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What does the New HPA Grouper Methodology Mean to OSC?

Total Procedure Count = 6,156

Multiple Count Projected at 20% = 1,231

Total Case Count = 4,925 ; **HPA = 20% of Volume**

Projected HPA Cases = (4,925 * 20%) = 985

Multiples paid at 50% of allowed

	<u>Initial</u>	<u>New</u>
Avg NR / Procedure	\$943	\$641
Avg NR / Multiples (NR/Pro *.5*.2)	\$94	\$27
Avg NR / Case	\$1,037	\$668

Total Projected Loss in Revenue / Income (((\$369)*985) = (\$363,465)

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What does the New HPA Grouper Methodology Mean to BSC?

	<u>Initial</u>	<u>New</u>	<u>Variance</u>	<u>% Change</u>
Avg NR/case	\$1037	\$668	(\$369)	-36%
Avg Cost/case	\$750			

Total Projected Income Initial Contract = \$282,695

Total Projected (Loss) Income Contract w/ New Groups = (\$80,770)

Grand Total Projected (Loss) Revenue ((-\$369)*985) = (\$363,465)

How does this compare to Medicare reimbursement?

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HPA Revenue Analysis				
Grouper Assessment - Medicare				
Initial Contract				
Payment Groupers	Volume	Percentage	Medicare Rates	Projected Revenue All procedures
1	670	11%	\$ 333.00	\$ 223,110.00
2	736	12%	\$ 446.00	\$ 328,256.00
3	484	8%	\$ 510.00	\$ 246,840.00
4	506	8%	\$ 630.00	\$ 318,780.00
5	310	5%	\$ 717.00	\$ 222,270.00
6	20	0%	\$ 826.00	\$ 16,520.00
7	108	2%	\$ 995.00	\$ 107,460.00
8	3138	51%	\$ 973.00	\$ 3,053,274.00
9	60	1%	\$ 1,339.00	\$ 80,340.00
10	124	2%	\$ -	\$ -
Total	6156	100%		\$ 4,596,850.00
NR / Procedure				\$ 746.73
Incremental Revenue Multiples				\$ 74.67
Total Avg NR/ Case Medicare				\$ 821.40

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What does the New HPA Grouper Methodology Mean to BSC?

Contract Value As Percent of Medicare After Grouper Changes = 81% of Medicare (\$668 / \$821)
(NR per Cs Contract/NR per Case Medicare)*100%

What happened to the 10% increase to 135% of Medicare?

Why did this happen?

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Administrator reviews contract language and finds the following items that were applicable to the changes made by HPA:

Payment Terms Section

“Plan may revise Exhibit A from time to time, based upon updated ASC CPT surgical grouping information that is provided by CMS, and/or may be modified by Plan to include surgical procedures that are considered for payment under this Agreement. ”

Amendment

“Plan may amend the language of the contract, rates and methodology, with a ninety (90) day written notice.”

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What are the implications of this Case Study?

Language

Methodology

What are the Administrator's next steps?

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Re-negotiate or Terminate?

Why is termination a serious consideration in this Case?

What is the process in this situation?

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Re-negotiation / Termination Evaluation Process:

- Review Termination Clause
- Determine Notification Requirements
- Make Contact with Provider Representative / Contract Negotiator
- Formal Written Notification of Intent to Amend the Contract
- Provide Resolution Time Period Expected
- Factor Losses into New Rate Proposal for Recovery

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What Rates Does OSC Need Under New Grouper Methodology?

How do you add in the Value of the Losses to the new proposal and Present the Argument to HPA?

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Complete the Grouper Shift Analysis

HPA Grouper Analysis					
Payment Groups	Volume New Payment Groups	Distribution Percentage	Volume Payment Groups (Initial contract - based on Medicare allocation)	Distribution Percentage	Group Variance (New - Old)
1	1318	21%	670	11%	648
2	384	6%	736	12%	-352
3	4140	67%	484	8%	3656
4	20	0%	506	8%	-486
5	150	2%	310	5%	-160
6	26	0%	20	0%	6
7	0	0%	108	2%	-108
8	0	0%	3138	51%	-3138
9	8	0%	60	1%	-52
10	110	2%	124	2%	-14
Total	6156	100%	6156	100%	

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Calculating the New Proposal:

HPA Contract Re-negotiation	
Preliminary Revenue Goal for Year 1	
Initial Contract HPA Revenue	\$ 1,021,445.00
Revenue due to Grouper Change	\$ 657,980.00
Net Loss	\$ (363,465.00)
Monthly Reduction	\$ 30,288.75
Projected Loss 4 months under new groups	\$ 121,155.00
Targeted Revenue under New Groups	\$ 1,142,600.00
Net Gain Required Over Existing	\$ 484,620.00
Targeted Revenue Increase Over Existing with New Groups	74%
Projected Avg Net Gain Per Case Needed to Meet Goal	\$ 492.00
Avg NR / Case Needed Overall	\$ 1,160.00

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Calculating the New Proposal:

HPA Counter Proposal Model						
HPA Payment Groupers	Volume	Percentage	Rates at 135% of Medicare (1-9) New Groupers as of Jan 1st	Rate Required to Meet Goal	Rate Required as Percent of Medicare	Projected Revenue All procedures
1	1318	21%	\$ 449.55	\$ 750.00	225%	\$ 988,500.00
2	384	6%	\$ 602.10	\$ 900.00	202%	\$ 345,600.00
3	4140	67%	\$ 688.50	\$ 1,150.00	225%	\$ 4,761,000.00
4	20	0%	\$ 850.50	\$ 850.50	135%	\$ 17,010.00
5	150	2%	\$ 967.95	\$ 1,855.00	259%	\$ 278,250.00
6	26	0%	\$ 1,115.10	\$ 1,115.10	135%	\$ 28,992.60
7	0	0%	\$ 1,343.25	\$ 1,343.25	135%	\$ -
8	0	0%	\$ 1,313.55	\$ 1,313.55	135%	\$ -
9	8	0%	\$ 1,807.65	\$ 1,807.65	135%	\$ 14,461.20
10	110	2%	\$ 575.00	\$ 575.00	n/a	\$ 63,250.00
Total	6156	100%				\$ 6,497,063.80
N/R Procedure						\$ 1,055.40
Incremental Revenue In Multiples						\$ 105.54
Projected Avg NR / Case						\$ 1,160.94

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How to Approach the Re-Negotiation

- Communication should be directed to the Network Contract Manager and/or the Provider Network Representative
- State the Facts
 - 1) Negative Grouper Shift
 - 2) The change in Methodology results in significant lost revenue
 - 3) The Contract now costs OSC to perform every case
 - 4) Contract rates now at 81% of Medicare while “Clearly the intent was to pay OSC at 135% of Medicare”
- Question the Amendment and Payment Policy Term Language with respect to Compliance

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- Provide a timeline for resolution (no less than 60 days recommended)
- Request Retroactive Compensation to Recover Losses
- Provide proposal that factors in losses
- Request multiple year contract with rate escalators and contract language that requires written amendment to modify methodology
- Imply that termination is an option without resolution within specified time period
- Subtle Approach

Lessons learned from the HPA Contract

- Always Read the Language of the Contract!
- Always read the “junk mail”
- Understand the Reimbursement Methodology
- Reject changes in methodology at time of Occurrence by sending rejection letter via certified mail
- Rejection letter should be sent before amendment clause expires (within the 90 day period in the case of HPA)

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What Should you Do When you Receive a “Dear Provider” letter?

- Business office should be instructed to be on the alert for these types of letters, which can sometimes be in the form of newsletters
- Understand the Methodology and the Implications that the Language of the Contract can have on Methodology
- Review the groupers carefully

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What Should you Do When you Receive a “Dear Provider” letter?

- Compare to Medicare groupers to identify variations
- Evaluate impact on existing contract compensation
- Reject the changes by writing a letter to the insurance company, if there is a negative impact on compensation
- Start re-negotiating the contract

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Consider if you really need to be a Preferred Provider?

Should I or Can I go Out-of-network?

Out-of-Network Reimbursement Questions to Consider

- Why be a contracted provider?
- Will I have access to patients?
- How do you go out-of-network?
- What are the implications to the patients?
- What are the implications to my physician partners?
- What are the implications to my center?

Going Out-of-Network: Pros

- Payments are typically higher
- Useful tool for de novo (new) centers – assists in cash flow
- May provide leverage in obtaining a contract
- Leakage may not be significant
- Medical staff don't have contracts

Going Out-of-Network: Cons

- Short term strategy
- ASC could be barred from a contract
- Patients pay higher out-of-pocket costs
- Physicians compensation could be penalized
- The payer may recoup overpayments
- Physicians may take other cases to a different facility (ASC leakage)

Always Remember...

Do your homework!

*Understand contract methodology and value as it
pertains to case mix!*

Knowledge is Power!

Relationships can Make or Break the Deal!

You won't get more unless you ask...always ask for more!



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