

# RON L. NELSON, P.A.

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## Managed Care for Rural Health Clinics

A system of providing health care services to enrolled members through a defined network of providers who have the responsibility of delivering quality services while controlling the utilization of resources



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## Integrated Delivery System

- Shift the focus of care
- ❑ From hospitals to health care systems
  - ❑ From specialists to PCPs
  - ❑ From acute care to prevention and primary care medical management



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## Staff Model HMOs

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- ❑ Providers are salaried employees of the HMO
- ❑ There is no incentive to provide unnecessary procedures or services



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## Group Model HMOs

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- ❑ Medical groups contract with HMOs to provide medical care to the HMO's subscribers
- ❑ Providers may also treat patients who are not members of the HMO



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## Physician Hospital Organizations (PHOs)

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A legal entity created by a hospital and a group of providers to obtain managed care contracts from insurance companies, employers, and MCOs



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## Capitation

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A fixed, periodic payment in exchange for delivering a defined set of services to a specific population group



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## Per Member Per Month (PMPM)

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Under capitation, the amount of money paid to practitioners/providers each month for each patient for providing a defined set of medical services



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## Determining the Capitation Amount

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Need to obtain an actuarial analysis of the cost of providing defined services to the proposed population of patients



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## Provider Profiling

The use of some measure of utilization/outcomes data for a defined patient population to compare a provider's practice patterns to the patterns of other providers



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## Information Management Tools

- Patient tracking
- Referral tracking
- Case management
- Quality and outcomes measurement
- Productivity reporting



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## Methods to Lower Treatment Costs

- Telephone triage
- Physician extenders
- Increased patient education
- Strict referral criteria
- Increased home and self care



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## Understand Your Value

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- In economic terms
- Indirectly
- Increased patient satisfaction



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## Negotiation

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- ❑ How does the plan address RHC services provided by PA/NP/CNM?
- ❑ Does the plan cover behavior health services? CP, CSW
- ❑ Is credentialing required?
- ❑ How do you credential PA/NP/CNM's?



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## Negotiation

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- ❑ Some issues in managed care may be negotiable
- ❑ Develop a rationale for desired contract changes



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## Negotiation

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- ❑ Will you sign a contract with the managed care organization or with your physician/corporation?
- ❑ Does the plan limit the types of medical services that you can provide?



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## Marketing

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- ❑ Do they have a Medicare or Medicaid population? What percentage?
- ❑ How many of my competitors participate?



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## Marketing

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- ❑ How many lives does the plan insure?
- ❑ Who are the major employer groups?
- ❑ Have any significant employer groups left the plan within the last three years? If so, why?



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## Financial condition of the plan

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- ❑ Have provider payments increased at the same rate as premiums?
- ❑ How competitive are the premiums?



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## Financial condition of the plan

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- ❑ Who owns the plan?
- ❑ What is the history of the plan's payments to providers?
- ❑ What is the experience of other providers?



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## Legal, Ethical and Financial Decisions

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- Withholds
- Economic profiling
- Deselection



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## Practice management

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- ❑ Do the UR policies compliment or contradict my practice methodology?
- ❑ How do I become involved and participate in utilization review?
- ❑ What are the credentialing requirements?



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## Practice management

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- ❑ What laboratories participate in this plan?
- ❑ Accessibility
- ❑ Complaints
- ❑ Pick-up and delivery



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## Practice management

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- ❑ What information does the plan require for authorizing hospital admissions?
- ❑ Is it necessary to certify length of stay?
- ❑ Are non-covered services defined?



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## Practice management

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- ❑ How will the plan educate my staff?
- ❑ How will the plan inform me of any policy or rate structure changes?
- ❑ Am I required to see a specific number of patients on this plan per day or week?



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## Practice management

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- ❑ Can staff call for results?
- ❑ How long for results?
- ❑ Am I comfortable with the lab standards?



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## Practice management

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- ❑ How do you handle disruptive patients?  
Can you terminate them?
- ❑ Are you notified when an enrollee is no longer eligible? Who pays for treatment if not notified?
- ❑ What services does Utilization Review (UR) track?



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## Reimbursement

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- How does the fee schedule compare to my usual and customary charges?
- How does the fee schedule compare to my cost per encounter, including procedures?
- What is the turnaround time for claims payment?



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## Reimbursement

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- Is their quoted price profitable?
- Can provider payments change without knowledge or consent of the provider?
- Can I limit the number of patients I take on this plan?



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## Reimbursement

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- Is there a plan for catastrophic coverage?
- Is there a methodology to adjust payment rates for adverse selections?



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## Reimbursement

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- ❑ How does this plan reimburse me? Am I paid by capitation, discounted fee schedule or a combination of both?
- ❑ Are office visits capitated?
- ❑ What procedures are capitated?
- ❑ Are lab and radiology services capitated?



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## Reimbursement

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- ❑ If I perform certain labs and/or x-rays in my office, will I be reimbursed?
- ❑ Does the plan have a "withhold" clause? If so, what are the terms of the "withhold"?



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## Legal/financial liabilities of the provider

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- ❑ If the plan decides to terminate a provider, how are they notified? How much notice is given?
- ❑ What is the policy for resolution of provider/plan disputes? Are providers represented on these committees? Is there a hold harmless clause?



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### Legal/financial liabilities of the provider

- ❑ What are the medical legal risks of the provider? Of the plan?
- ❑ If the plan goes bankrupt who is liable for the outstanding claims for services provided by other providers for your enrollees? Who is responsible for continued treatment?



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### Legal/financial liabilities of the provider

- ❑ Am I required to belong to this managed care organization exclusively?
- ❑ In joining this plan am I also joining any other plans that have contracts with this organization? If I join, will physician's names or group name be used to solicit other providers?



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### Legal/financial liabilities of the provider

- ❑ Can the plan be merged with another plan? If so, what are the rights of the provider?



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## Contracting Issues

- ❑ How are incidental services such as injections paid for?
- ❑ Do co-pays differ for RHC vs. Non-RHC providers?
- ❑ Recognize RHC services as separate from Part B; i.e.: clinic visits, hospital admission same day
- ❑ Definition of core RHC services; i.e.: SNF, patients home, RHC, "Incident-To" services



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## Contracting Issues

Tracking data

- ❑ Will the plan provide PS&R type of report?
  - Visits
  - Co-pays
  - Deductible
  - Payments



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## Contracting Issues

- ❑ Will data report provide break down by provider type for:
  - Visits
  - Co-pays
  - Deductible
  - Payments



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CHECK THESE ITEMS WHEN YOU ARE DONE TO VERIFYING

WORKSHEET 7 - PAYMENT LOG			
Payment Types:	Note: Payment amount received is based on DATES OF SERVICE for the CODE REPORTING PERIOD, not WHEN the payment was received.		
Medicare Payments			
Lump Sum Adjustments from Medicare			
Medicaid PPS Payments			
Medicaid Quarterly Payments			
Other Third Party Payments (i.e. primary insurance's, health's, Medicare that have paid when Regular Med. is the secondary insurance)			
Medicare Beneficiary Deductible Received (Payments made by the Medicare Patient)			
MEDICARE ADVANTAGE PLANS:		End-of-Sector Payments	Total Payments
Medicare Advantage Plan Payments (By each MA Plan) - Please List name of MA Plan			
Medicare Advantage Plan Payments (By each MA Plan) - Please List name of MA Plan			
Medicare Advantage Plan Payments (By each MA Plan) - Please List name of MA Plan			
Medicare Advantage Plan Payments (By each MA Plan) - Please List name of MA Plan			
MEDICARE QHP/INTELL CLASS:		End-of-Sector Payments	Total Payments
Medicaid QHP Payments (By each QHP Plan) - Please List name of QHP			
Medicaid QHP Payments (By each QHP Plan) - Please List name of QHP			
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## Negotiation

- ❑ Negotiate rates – when are rates adjusted?
- ❑ Year End Settlement
- ❑ Vaccine Payment/Influenza/Pneumococcal
- ❑ Fee schedule vs. full cost




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## Negotiation

- ❑ Medicare bad debt allowance
- ❑ Claims processing UB92 (1452) or 1500 for core services
- ❑ Time frame for payment of clean claims
- ❑ How are rate changes addressed and when?




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## Summary

- ❑ Negotiate – critical for RHCs not to accept without negotiation
- ❑ Giving up cost settlement has value – what are you receiving?
- ❑ Be prepared to negotiate the best rate for your RHC. Don't assume you must accept what is being offered without analyzing the impact on your RHC.



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## How will Pay for Performance be considered in cost based environment?

- ❑ Medicare?
- ❑ Medicaid?
- ❑ Commercial



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## Pay for Performance

System to pay premium or fees based upon certain outcomes.

Payment based upon achievement of certain agreed upon thresholds for quality outcomes (i.e. vaccinations of all children < 24 month threshold 90%)

Payment usually paid PM/PM if met or annual depending on criteria.



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## Pay for Performance

Requires criteria to measure against system to collect data.

Examples:

70% of patients assessed and advised regarding nicotine use – (Annual)

80% all children under 24 months up to date on immunizations according to CDC Standards (PM/PM)



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## Examples of Pay for Performance Initiatives

- ❑ Vaccines
- ❑ Chronic Disease Management
- ❑ Preventative Services (i.e. pap smear, colon cancer screening)



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## Examples

- ❑ Smoking Cessation
- ❑ Mammography
- ❑ Colon Cancer Screen
- ❑ Tobacco status and advice
- ❑ BMI



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## Chronic Disease Models

### Diabetes

- ❑ HbA1c < 7% (3 x year)
- ❑ LDL < 100 mg/dl (6 months)
- ❑ Retinal exam (Annual)
- ❑ Microalbumin (Annual)
- ❑ Controlled BP < 130/80




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## Data Collection

- ❑ EMR Systems optimal
- ❑ Billing records – collect data from payment system




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## Example

- ❑ 150 children with every appropriate Well Child Visit at \$75.00 and immunizations at \$25.00 per visit.

### *Typical Newborn Well Child*

	Visit:	Immunizations:
Newborn Exam	\$75.00	
2 Mo.	\$75.00	(5) \$125.00
4 Mo.	\$75.00	(5) \$125.00
6 Mo.	\$75.00	(5) \$125.00
9 Mo.	\$75.00	(5) \$125.00
12 Mo.	\$75.00	(5) \$125.00
<b>Total:</b>	<b>\$450.00</b>	<b>\$475.00</b>

Total potential payable: \$925.00 x 150 = **\$138,750.00**

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## Examples

### *Administrative Bonus:*

- \$1.00 per member per month for open sites
- 1000 members x \$1.00 = \$1,000 per member per month x 12 = \$12,000 per year
- All bonus payments are retained by RHC/FQHC



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## Pay for Performance Example

### Vaccines:

- \$.25/medicaid recipient under age 21  
<25% of children age 24 months up to date
- \$.50/medicaid recipient under age 21  
75% - 89% of children age 24 months up to date
- \$1.00/medicaid recipient under age 21  
> 90% of children age 24 months up to date



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## Example of Impact in Dollars

**500 patients enrolled with your practice as PCP**

500 patients x \$1.00 (90%) = \$500/month

500 patients x 12 = \$6,000/year



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Smoking Cessation

Chronic Disease

- Diabetes
- Hypertension
- Asthma



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**Pay for Performance**

Goal – Improve quality and reduce costs by providing financial incentive.



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**Potential Impact on Bottom Line**

Medicaid	\$6,000/year
Commercial	\$6,000/year
	\$12,000/year



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## Strategies to Improve Pay for Performance

- ❑ Requires understanding of models
- ❑ Requires systems to improve quality and that outcomes are met (tracking)
- ❑ Requires commitment to process



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## Common Terms

PFFS – Private Fee for Service  
RPPO – Regional Preferred Provider Organization  
PS&R – Provider Statistical and Reimbursement  
Co-Pay – Payment required associated with a service.  
SNF – Skilled Nursing Facility  
CP – Clinical Psychologist



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## Common Terms

CSW – Clinical Social Worker  
PA – Physician Assistant  
NP – Nurse Practitioner  
CNM – Certified Nurse Mid-wife  
UB92 – Part A billing format  
1500 – Part B billing format  
**CMS** – Centers for Medicaid and Medicare Services



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## Common Terms

Provider – based – RHC is integral part of a provider operated as a unit of the provider with common systems for management.

Independent – free standing rural health clinic

AIIR – All Inclusive Interim Rate



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## Medicare Advantage Implications for RHCs



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## Medicare Advantage

In many plans coverage maybe better than Traditional Medicare (cannot be less).

RX portion has deductibles and co pays based upon formulary.



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## Medicare Advantage

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**Provides for two types of plans**

- ❑ PFFS – Private Fee for Service
- ❑ Regional/PPO Plans
  - Must provide service to the entire region as defined by CMS.



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## Negotiation

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- ❑ Some issues in managed care may be negotiable
- ❑ Develop a rationale for desired contract changes



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## Negotiation

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- ❑ Who are the major employer groups?
- ❑ Plans are developing products to insure retirees
- ❑ You may be accepting MA products because of change in retiree benefits



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## Contracting Issues

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### Tracking data

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## Cost Reporting (Analysis)

- ❑ Do I count the MA visits?
- ❑ Count all visits in total
- ❑ Only cost settle regular Medicare with FI



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## Cost Reporting (Analysis)

- ❑ MA (PFFS) Visits x Current Rate = Reimbursement
- ❑ Compare this to your actual payments
- ❑ Payments from MA (PFFS) visits
- ❑ Make sure you compare core RHC services and visits



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## Questions?

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