

## **Improving Managed Care Contract Performance**

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### **I. Background**

The rise of managed care in the United States has required healthcare providers to evaluate many healthcare issues. Hospitals must address issues related to finance, quality of care, and relationships with managed care organizations. Managed Care is a generic term for the myriad organizational arrangements that integrate the financing and delivery of health care in such a way that the former constrains the latter. It combines the business of insurance with the delivery of professional health care services. Managed care organizations secure enrollees by offering the purchasers of insurance (employers and government) competitively priced enrollment premiums and providing enrollees fair access to quality health care within a finite budget”(Gervais & Vawter, 1999, p.1).

Managed care in the United States began with prepaid group health care cooperatives in the 1940s. This was in response to the consequences of fee-for-service indemnity insurance which had led to overutilization and inconsistent health care quality in the delivery of health care services. The passage of the 1973 HMO Act led to a new strategy to compete with the fee-for-service plans.

Additional cost control mechanisms were implemented in the early 1980s when the Medicare program began reimbursing by diagnosis related groups. Hospitals were forced to deliver services within the diagnosis related group or incur substantial financial loss. The financial loss of this system was cost-shifted to private insurance which led to increased premiums for purchasers of indemnity coverage.

Employers bearing this burden sought out managed care plans as a means to offer low cost insurance to their employees. By the mid 1990s, nearly two-thirds of insured employees were covered by some form of managed care. In 2003, 95% of covered workers were enrolled in

HMO, PPO, or POS managed care products. Only 5% of covered workers remain in indemnity plans according to Henry J. Kaiser Foundation statistics. Cost containment has been the primary focus of managed care organizations. However, the more restrictive contracts with physicians and hospitals resulted in a perception by the enrollees that they had considerable less choice. Court battles over denied care and medical necessity issues led to the proposal of patient's bill of rights.

The present managed care environment remains in a state of flux. Gabel and Fitzner found that American health care consumes about one-seventh of the United States' economy. Per-capita healthcare costs in 1999 were 53% higher than in any other nation. In 2001, national health care per capita expenditures reached \$5,039. Projected per capita expenditures may reach \$8,885 and 17.1 % of GDP by 2010. Medical expenditures reached a low point in 1996, but have accelerated in subsequent years. "In 2001, medical expenses increased by 10%, with the cost of outpatient hospital services and pharmaceuticals greatly exceeding this overall figure" (Gabel and Fitzner, 2003, sp1). During the first half of 2003, health plans have posted impressive profit gains. Premium increases have reached double digits and are not expected to taper off until 2005. Employers who are bearing the brunt of the premium increases are looking for creative ways to absorb the financial impact without substantially increasing employee out of pocket expenditures.

"Despite reports to the contrary, managed care is pervasive and growing. By understanding employers' needs and how those needs are forcing managed care to change, hospital and physician provider organizations can create growth opportunities for themselves. To optimize their organizations' financial performance under managed care contracts, healthcare financial managers of providers should develop an overall managed care strategy for their organizations that includes customer-service initiatives and system planning and development, instead of focusing only on contract negotiation" (DeMarco, 2003, p. 42).

## **II. The Hospital Managed Care Scenario – A Case Study**

The community hospital is located in a rural county with the population of 46,005 based on 2000 census data. This county is the primary market area for the Hospital. In 2001, 89.9% of all

inpatient admissions resulted from the county residents. According to the 2002 Hospital financial statistics, there were 3,563 admissions. Length of stay remained low at 3.7 days. Outpatient visits have climbed steadily in recent years and reached 111,708 in 2002. Cost per discharge and cost per visit are running slightly below the median quartile for hospitals of similar size. The contractual allowance percentage is below the lower quartile. These ratios are considered to be favorable.

The Hospital is currently enrolled in twenty-nine health plans. In 2002, the managed care payor mix was approximately 29 percent (Attachment A). Separate contracts are in place for home health and transitional care. The types of health plans include traditional indemnity, preferred provider (PPO), and health maintenance (HMO) arrangements. The majority of reimbursement arrangements include a discount on fee-for-service. Several other types of reimbursement arrangements include a per diem payment arrangement in addition to discounts for some services, a case rate for payment of obstetrical care, and diagnostic related groups (DRG) for inpatient services with outpatient services paid on a discounted basis.

While discounts on charges are by far the most prevalent payment mechanism, it is expected that the Hospital would be pressured to increase financial risk by including other reimbursement arrangements in future health plan contracts. Per diem payment, which is a predetermined set rate per day varied by service or uniform regardless of intensity of service, presents an increased risk over the discounted service arrangement for inpatient care. Capitation, a method of payment for health services in which providers are paid a predetermined, fixed amount of money per enrolled member per time period for contractually agreed upon services to a specifically defined population, presents the greatest risk.

Reimbursement by capitation was driven by the need to reduce health care expenditures and increase efficiency. Proposed federal and state legislation involving managed care contracting and reimbursement was carefully assessed. Capitation was predicated to become the prevalent method of reimbursement to providers. In the mid 1990s, roughly fifteen (15) percent of the 32.9 million national Medicaid beneficiaries and 2.6 million of the 36.6 million Medicare beneficiaries were enrolled in a capitation plan. By 2003, Medicare Choice enrollment

decreased to 11% of the total Medicare population. It was uncertain how quickly this payment mechanism would emerge in the rural health care market. On the outpatient side, ambulatory surgical case rates were beginning to replace traditional discounts on charges. Ambulatory surgical case rates most likely would be modeled after the Medicare ambulatory surgical case rates already in place.

The primary goal in the evolution of managed care at the Hospital continues to maximize the fee-for-service arrangements for as long as they are available. Fee-for-service arrangements present the least financial risk to the Hospital. At the same time it is important for the Hospital to begin to develop strategies to adapt to changes in the health care environment.

An internal assessment of all current Hospital health plan contracts was completed. After compiling information from the internal assessment, several factors were identified:

#### Contracts

Some standard contract language was identified after reviewing all the contracts. While each contract is negotiated under different circumstances, some standardization of agreements is possible in future contracting. The review of PPO contracts revealed the difficulty in tracking payors to plans. In some plans, for example, a payor may be an employer, insurance carrier, self-funded plan, association, trust fund, health maintenance organization or competitive medical plan that provides a health benefit to participants. This type of payor arrangement is labeled a silent PPO because discounts are offered without providing incentives to use the Hospital services. Contract management software used to track appropriate payment according to each managed care agreement also helps to identify this type of arrangement.

### **III. Recommendations for Improving Contract Negotiations**

#### Clinical Pathways and Practice Guidelines

An integral part of the managed care transition process is developing a framework for monitoring performance and establishing strong utilization and quality controls. Clinical protocols for standardization of equipment and ancillary usage can enhance efficiency and cost reduction. Several clinical pathways have been developed for diagnoses that are high cost, high volume, or

problematic in length of stay. Clinical practice guidelines that are being developed by university hospitals will be available and may be used to structure a “best practice” scenario which may help to maximize outcomes and reduce costs. Ideally, a cost model applied to those “best practices” would provide valuable information to demonstrate both the cost and value of health care at the Hospital.

#### Customer-Service Initiative

“To remain competitive in markets where the new, consumer-focused products are being offered, health care providers should focus on improving customer service and management of delivery systems so that their prices, convenience, and quality are attractive to consumers” (DeMarco, 2003, p.44). In 2002, several customer services initiatives were presented to the Board of Trustees during their annual retreat. An employee survey was completed regarding the customer services at the Hospital. This was followed by customer service training to all employees. A new employee recognition program called the Cause for Applause was initiated with excellent results. The Mentor Program was expanded with the addition of new service excellence leaders. Another program is planned in the near future which will expand the initiative and provide additional training for management, mentors and general staff. “Consumers typically choose a provider on the basis of their experience with that provider. It therefore is critical for providers to focus on enhancing quality and consumer relations” (DeMarco, 2003, p.44).

#### Contract Negotiation

A process for planning contract negotiation strategies has been established. Categories for establishing a priority system for negotiation strategy has been implemented (Attachment B). Contract guidelines/checklists to reference the most desired language have been considered. (Attachment C).

#### Negotiation Team

The negotiation team was determined to be an appropriate mechanism to manage the contracting process. Membership includes President/CEO, Vice President Fiscal Services, and the Vice President Managed Care/Compliance. Support from information systems, business office, case coordination, and finance will be necessary. It is expected that the responsibilities of the team will evolve and all members may not participate on a formal basis. The Vice President Fiscal Services and the Vice President Managed Care/Compliance are the contacts for the actual negotiations with the health plans.

The service areas which are expected to receive the greatest impact in future contracts were prioritized. Inpatient per diem rates and outpatient surgical case rates may evolve as the next contract reimbursement concerns after discount on fee-for-service is less of an option. A model or tool to determine the cost in these areas should be selected and used to review the impact on Hospital reimbursement. The Care Coordination Department has guidelines based on information from Milliman & Robertson, health actuaries that may be useful to initiate the process. This information coupled with current market trends in managed care and careful review of internal Hospital charge data and DRG reports serve as the best option to approach reimbursement issues. The impacts of the growth of managed care in the areas of Medicare, Medicaid, and Workers' Compensation have also been considered. Clinical pathways and practice guidelines became tools to demonstrate "best practice". Consideration of cost and value of selected practices have evolved. This was determined by available resources, i.e., information system capabilities, financial, and human resources.

#### *Medical Information*

A proactive approach to medical information management has been taken. More medical information involving medical outcomes is being requested by managed care entities during initial and subsequent contracts. The managed care negotiation team has been instrumental in determining how to present Hospital specific data to best serve our needs during contracting.

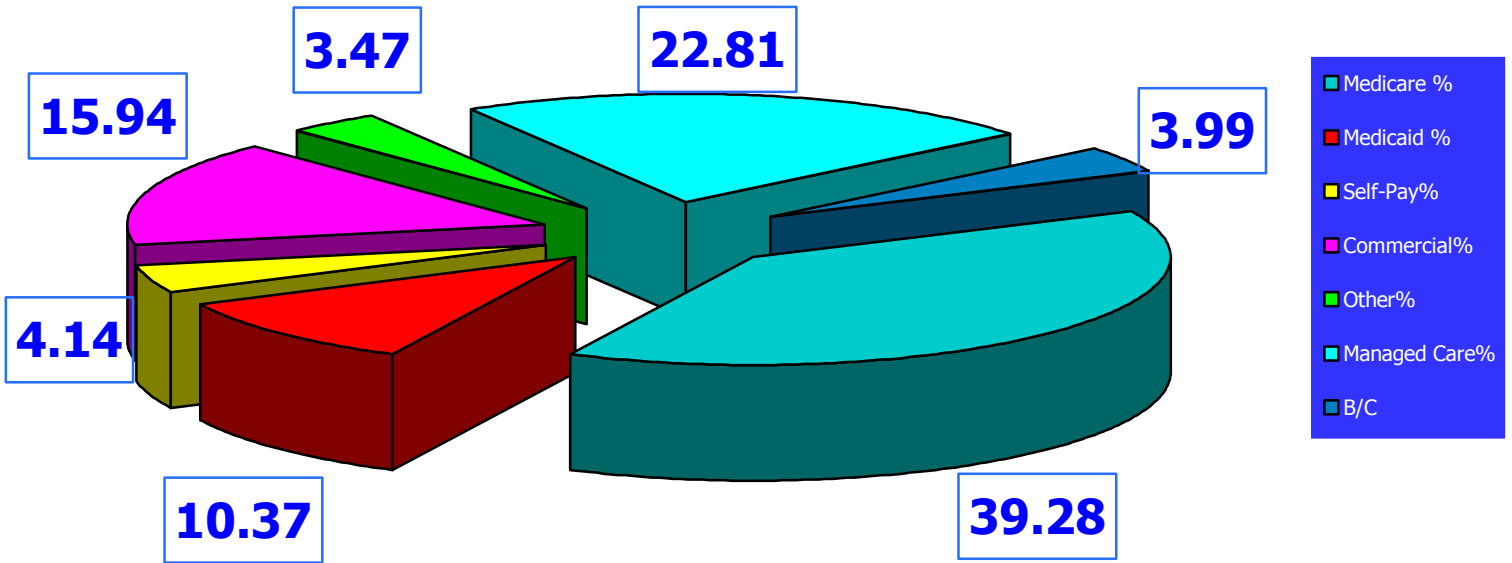
#### **IV. Conclusion**

A sound strategy has been adopted by the Hospital that includes the standardization of contract language to the maximum extent possible, practice guidelines and customer service initiatives. Current managed care market trends and internal Hospital reimbursement data are reviewed as part of the managed care strategy. The managed care environment is constantly changing and requires close monitoring to optimize opportunities for the Hospital. A fine balance exists between remaining competitive while setting rates that assure fiscal expansion (survival) of the Hospital. The Hospital must continue to negotiate rates that allow for the overall improvement of the health care delivery system at the local level.

# Payor Mix

Attachment A  
Case Study: Sample Rural Hospital Pay Mix

## YTD 2002



MANAGED CARE CONTRACT  
GRADING RATIONALE  
Attachment B

*CATEGORY A*

Managed care agreements that required a proactive approach and more flexibility in negotiation strategy.

- X Large national HMOs
- X National PPOs that are not “rent-a-networks”

*CATEGORY B*

Managed care agreements that are desired, but require less flexibility in negotiation strategy.

- X Regional or small HMOs
- X Large or national PPOs that are not just selling discounts

*CATEGORY C*

Managed care agreements that are negotiated on a standard “take-it-or-leave-it” approach.

X Small PPOs or any PPO that is primarily a “rent-a-network”

*UNGRADED*

X Medicare Select products

## CONTRACT REVIEW GUIDELINES

### Attachment C

#### A. PREAMBLE

1. Parties Agreement is by and between (Managed Care Organization) and Hospital (“Hospital”).

#### B. DEFINITIONS

1. Defined Terms Any terms used specifically (i.e., capitalized) in contract should be defined.
2. Medical Necessity Defined by community standard, not Plan standard.

#### C. PLAN RESPONSIBILITIES

1. Directional Incentives Financial incentives will be provided to Members to encourage use of Hospital or discounts do not apply. Minimum 10% co-insurance incentive.
2. Payors (PPO Plans) If Plan is not the Payor; Hospital needs a listing of payors as contract attachment, with thirty (30) day prior notice of any additions/deletions to list. List to include claims administrator and UR company address/phone. Plan not to be marketed to other PPOs, HMOs, or other insurance companies without Hospital’s prior written consent.
3. Medical Records Plan to secure patient authorization for release of records. Negotiate the current standard copying fee, if possible.
4. Provider Directories Copies to be provided to Hospital within thirty (30) days of each revision/publication, if plan does not use website.
5. Plan Network Specify Plan’s current Hospital network for relevant geographic

area.

6. Utilization Review Determinations to be based on medical necessity, not the Plan's unilateral determination. Appeals procedure should be specific.
7. Plan Names Specify name and brief description.

### **HOSPITAL RESPONSIBILITIES**

1. Hold-Harmless All contracts-HMO only as required by law.
2. Pre-certification  
EMERGENCY - within two (2) business days (could negotiate to one (1), if necessary).  
NON-EMERGENCY - prior to admission  
OUTPATIENT - Negotiate no Hospital responsibility, if possible,
3. Utilization Review On-site review for exception cases only and in accordance with Hospital policy and procedure. All UR should be specified as being in accordance with Hospital policy and procedure.
4. Manuals Resist specification that are per "current Provider Manual". If required, need thirty (30) days notice of any material changes to manual. Date of current manual should be specified in contract and reviewed prior to signing.
5. Medical Records Access for one year following agreement termination or date of service, whichever is sooner.
6. Services Define services covered by Agreement, or note exclusions ("carve outs"). This is absolute for capitation agreements.

## **E. BILLING**

1. Claims Submission            180 days to submit claim.
  
2. Claims Payment            Payment to be made within thirty (30) days from receipt of claim, including repricing or in accordance with Prompt Pay Law. EOB to specify applicable contract. Negotiate to have payment revert to 100%, if not received within specified time.
  
3. Claims Denial            Appeal procedure must be specified. Operational denial: Negotiate for “penalty” fee rather than total denial.
  
4. Over/under Payments      Hospital has the right to re-bill if underpaid. Hospital will agree to like language re., overpayments. Limited time frame of one year for re-billing, if mutually agreed.

## **F. TERM/TERMINATION**

1. Termination            30 days - with cause (included time to cure)  
   180 days - without cause  
   Immediate - bankruptcy, insolvency, loss of licensure
  
2. Term/Renewal            Specify effective day and annual renewal date, Indicate whether dates apply to admissions or discharges on or after \_\_/\_\_/\_\_. New rates to be agreed upon within 60 days after renewal date or either party may terminate immediately.

## **G. MARKETING**

1. Provider Listings            Plan will list Hospital as provider. Hospital may/will list Plan in listing of plans in which it participates. No other use of Hospital name with Hospital’s prior written consent.

2. Marketing Plan will promote Hospital to the same extent it promotes other participating hospitals.

## **H. MISCELLANEOUS**

1. Indemnification Each party agrees to indemnify, defend and hold harmless the other, its agents and employees from and against any and all liability or expense...
2. Insurance Negotiate to maintain general and professional liability coverage at the current amounts approved by the Board of Trustees.
3. Dispute Resolution Mediation or binding arbitration in accordance with the American Arbitration Association in the jurisdiction of the Hospital's domicile.
4. Governing Law Ohio or not specified.
5. Assignment None without prior written authorization.
6. Notices Hospital President/CEO or Vice President Fiscal Services.
7. Addresses/Phones Required for claims submission and utilization review.

## **I. REIMBURSEMENT**

1. Reimbursement Terms Specify appropriate DRGs, ICD-9s, etc. Do not apply stop loss to percentage rates.
2. Plan Specifics If Plan uses its own DRG weights or ASG groupings, specify updates will be provided 30 days prior to their effective

date. Hospital and Plan will renegotiate terms if effect of re-weighting is greater than three (3) percent.

3. Outpatient Fee Schedule  
Base on CPT codes.
4. Hospital-Base Clinics  
Plan will reimburse for hospital-based clinics. Define as they are formed.
5. Capitation  
Specify: which members capitation is calculated, services included/excluded, covered services defined per member handbook (attachment), date of payment, policy regarding payment for member enrolled mid-month, payment based on most recent enrollment listing, enrollment listing provided with payment (electronic format preferred), risk sharing with physicians (specify distribution mechanism with example), method for reconciling capitation payments (members enrolled or disenrolled but not reflected in capitation payment) reports.

## **J. SIGNATURES**

1. Signatures  
President/CEO or VP Fiscal Services

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