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Managed Care Contracting for ASCs: Current Trends, Challenges and Tactics to Obtain Great Results

75-minute audio conference

May 8, 2008

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1:00 p.m.–2:15 p.m. (Central)
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Welcome!

We are pleased that you have chosen to set aside a part of your day and join us for our **Managed Care Contracting for ASCs: Current Trends, Challenges and Tactics to Obtain Great Results** audio onference with **I. Naya Kehayes** and **Caryl Serbin.** We are sure you will find the conference educational and worth your time, and we encourage you to take advantage of the opportunity to ask our experts your questions during the audio conference.

If you would like to submit a question before the audio conference, please send it to *rob@beckersasc.com*. Although we cannot guarantee your question will be answered during the program due to time constrictions, we will include it if time permits.

If you have comments, suggestions or ideas about how we might improve our audio conferences, or if you have any questions about the audio conference itself, please do not hesitate to contact me.

Thanks again for taking part in this program.

Sincerely,
Robert Kurtz
Director of Communications
Phone: (410) 874-7681
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Speaker bios

I. Naya Kehayes, MPH, CEO and founder of Eveia Health Consulting & Management (EHCM), formerly Millennium Health Consulting, LLC. Ms. Kehayes is specialized in managed care, ASC operations and financial management. Through EHCM, she provides managed care contracting direction and consultation to several national ASC corporations. She is nationally recognized as an expert in reimbursement methodologies and managed care contract negotiations, as well as ASC financial and operations analysis. Moreover, Ms. Kehayes provides formal presentations nationally, on ASC business, operations and managed care contracting related topics.

Prior to founding Millennium Health Consulting, LLC dba Eveia Health Consulting & Management (EHCM), Ms. Kehayes was a regional director of National Surgery Centers, and maintained administrative responsibility for Seattle Surgery Center and Laser Northwest. She coordinated a Corporate Managed Care resource team nationwide for over 40 ASCs and was responsible for orthopedic development in the Northwest. Prior to that, Ms. Kehayes was a surgical hospital administrator for Columbia/HCA Healthcare Corporation and held a variety of administrative service positions at hospital and healthcare ancillary service affiliates of Harvard University, Yale University and the University of Rochester.

Caryl Serbin, RN, BSN, LHRM, president and founder of Surgery Consultants of America, a development and management company for ASCs, and Serbin Surgery Center Billing, an ASC billing and coding company. Ms. Serbin has more than 25 years' experience in the healthcare industry, with the last 18 years spent in ambulatory surgery administration and consulting. Her companies provide development, management and billing services for numerous freestanding and hospital joint-ventured ASCs.

As a recognized leader in the industry, Ms. Serbin presents extensively at ASC national seminars and association meetings, authors articles on ASC-related topics, serves on the board and contributes regularly to industry publications. She was recognized in Who’s Who in the Ambulatory Surgery Center Industry in 2005 and was chosen as the 2007 spokesperson for AAASC to present a series of educational seminars on the changing CMS payment system and its impact on ASCs

Presentation

by **I. Naya Kehayes, MPH** and **Caryl Serbin, RN, BSN, LHRM**

I. Naya Kehayes, MPH, CEO & Managing Principal
Eveia Health Consulting & Management

Managed Care Contracting for ASCs:
Payor Trends, Market Assessment and Impact on Negotiation Strategy

Health Insurance Consolidation and Strategy….

How Is This Impacting Your Market and Negotiating Position?

Facts…Payor Consolidation

- 96% of major markets have at least one commercial payor with a market share of 30% or greater
- 64% of major markets have at least one commercial payor with a market share of 50% or greater
- 24% of major markets have at least one commercial payor with a market share of 70% or greater

Source AMA 2007 Update – Competition in Health Insurance

Facts…Payor Consolidation

Wellpoint, Inc. formed as a result of the 2004 merger of Wellpoint Health Networks, Inc and Anthem, Inc.

Who is Wellpoint as a result of the merger with Anthem?

- The largest health insurer and has acquired 11 health insurers since 2000
- 34.8 million covered lives
- Anthem Blue Cross Blue Shield of Colorado, Connecticut, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio, Virginia, and Wisconsin
- Blue Cross of California & Blue Cross Blue Shield Georgia
- Empire Blue Cross Blue Shield of New York
- HealthLink and UNICARE

Facts…Payor Consolidation

United Healthcare Group (based upon 2007 published statistics)

- Second largest health insurer
- 33 million covered lives
- 11 acquisitions since 2000

United Healthcare recently acquired plans...

1) **PacifiCare (west and southwest)**
2) **MAMSI (mid Atlantic)**
3) **John Deere (Midwest)**
4) **Oxford Health Plan (northeast)**
5) **"Strategic Alliance" with Harvard Pilgrim**
6) **Sierra Health Services (completed February 2008)**

Facts…Payor Consolidation

United's Acquisition of Sierra Health Services Impact on Market:

- Potential to control 56 percent of the Nevada market compared to 11 percent, prior to acquisition
- United has to divest Secure Horizons Medicare Advantage product in several counties
- Secure Horizons business goes to Humana
- United & Sierra reach an agreement with Nevada Attorney General to make $15 million in charitable donations over 5 years to benefit health care consumer in programs in Nevada

Facts…Payor Consolidation

Other Important Facts about Payor Consolidation:

- Wellpoint & United have combined membership of over 67 million covered lives
- Wellpoint & United control 36% of the national market for commercial health insurance
- In 2004 & 2005, 28 mergers valued at $53.8 billion were completed or announced, exceeding the value of all deals completed in the previous 8 years

Facts…Payor Consolidation

MultiPlan acquires PHCS Q4 2006

Cigna Activity

- Cigna forms an "alliance" with MVP – Q1 ''07
- Cigna completes acquisition of Great West April 2008 adding 1.9 million covered lives
- Cigna services approximately 47 million members in the US and nationally

Aetna Activity

- Aetna purchases Schaller Anderson in 2007 who administers physical and behavioral health for Medicaid, Medicare and commercial self funded plans in 9 states

Aetna purchases networks…

- PPOM in Michigan
- Sloan's Lake in Colorado

Networks & Alliances

- Rental Networks … vs. Strategic Alliances … *What does this mean?*
- Did you really just sign a contract at 60% of billed charges?
- Who are you contracted with? What contract rates prevail?

  Contract Language Example: *Provider agrees to allow the payor to enable other payors access to ancillary provider services under this agreement*

Examples of Rental Networks:

1) Multiplan
2) First Choice
3) Beechstreet
4) Three Rivers

- What is a strategic "alliance"? When the payor needs coverage in a market and does not sell their product in that market

Networks & Alliances

- Why do payors rent networks and form strategic alliances?

  1) Products are not competitive for the market – payor does not have the membership that warrants a sales force and contracting team

  2) To reduce out of network expenditures

  3) Enables the payor to service a national employer

- Network participation is impacted by employer contract with the insurance company

- Employees may or may not select network access based upon employer contract with the insurance company

Assignment of Contracts

When mergers and acquisitions occur, what contract prevails?

- Payor consolidates contracts
  Assignment Language
- Payor moves to most beneficial payment system as a result of merger or acquisition
- What should you do when a payor merges in your market with another plan?
- Are you giving the better deal to the payor with less market share?
- How does this impact your position at the time of a merger?

What other insurance company & market trends impact ASC negotiations and your ability to secure contracts?

How does your market position impact your strength for negotiation with payors?

Other Trends

Hidden ASC Providers

- Anesthesiologists, Radiologists, Lab
- Credentialing Criteria
- How do payors use ASCs to attain network participation by hidden providers?
- Hidden providers can be used as a vehicle to reducing ASC compensation

Accreditation

Assessing your Market Strength

Market position impacts power to negotiate – important questions

- What makes your ASC different?

  Single Specialty
  Multi Specialty
  Hospital Based

- Do you have equipment or provide services patients cannot access anywhere else?

Assessing your Market Strength – Alignment with Partners

- Are you aligned with your physician partners?
- Are your partners part of the payor's network?
- ASCs are a redundancy
- Physician partners may be critical to your success – how can they help you with your payor relationships?
- Can you work with your partners to move cases from the hospital with adequate and reasonable reimbursement?
- How do you quantify this for the payor?

Educate the Payor

Can you show the payor you can move cases with reasonable and adequate reimbursement?

- What data do you need?

- Access HOPD data and demonstrate how the ASC provides cost savings opportunity to the payor by moving more cases from the hospital ***(see HOPD reimbursement and cost data sample - Handout)*.**

  For complete list and updates, go to: http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CMS1392FC_Median_File_by_HCPCS.zip

Challenges for Payors

- Why can extending a contract to your center or changing the parameters of coverage be a challenge for payors in some markets?

  Payor Considerations:
  High Volume Surgery
  Spine
  Orthopedics

- Do ASCs really represent a cost savings to payors?

- How does this impact New Centers vs. Existing Centers?

Things to Remember…

- Understand who you are contracted with and how mergers can change existing payment rates and terms
- Network participation may reduce payment rates
- Understand assignment language
- Educate payors about your market strength and how you add value to their network
- Alignment with physicians may impact ASC's ability to contract with payor
- Educate the payor and maintain a positive relationship!

SECTION II: CONTRACT NEGOTIATIONS AND MANAGEMENT

Presented by
Caryl A. Serbin, RN, BSN, LHRM

Doing last-minute contracting will result in a contract that's not worth having!

PREPARATION

START EARLY

- Realize that negotiations now usually take between 3 and 6 months to complete
- MCOs may require new centers have Medicare number or AAAHC accreditation
- Form a focus group of at least two people for negotiations
- Target specific MCO representative(s) and negotiate only with them
- Develop a tracking spreadsheet showing each new offer or change in allowances

PICKING PLANS

- List the plans in order of those with the largest number of contract holders in your area
- Next choose the plans that make up large patient volumes for your referring physicians
- Choose well-known plans to begin your negotiations, i.e., Blue Cross, Aetna, UHC, etc.

PICKING PLANS

- **Determine financial stability of lesser-known plans by checking with your state insurance commissioner**
- **Get information about potential plan**
  - **market share**
  - **history in your market**
  - **types of products (PPO, HMO, POS)**
  - **breakdown of members by type**
- **Don’t create a “loss leader” in order to attract physicians**

CASE COSTING

- **Establish your reimbursement needs prior to negotiations:**
  - **calculate costs for common cases**
  - **determine your desired profitability margin**
  - **ascertain your break-even amount**
  - **decide on the lowest rate acceptable**

FIRST CONTACT

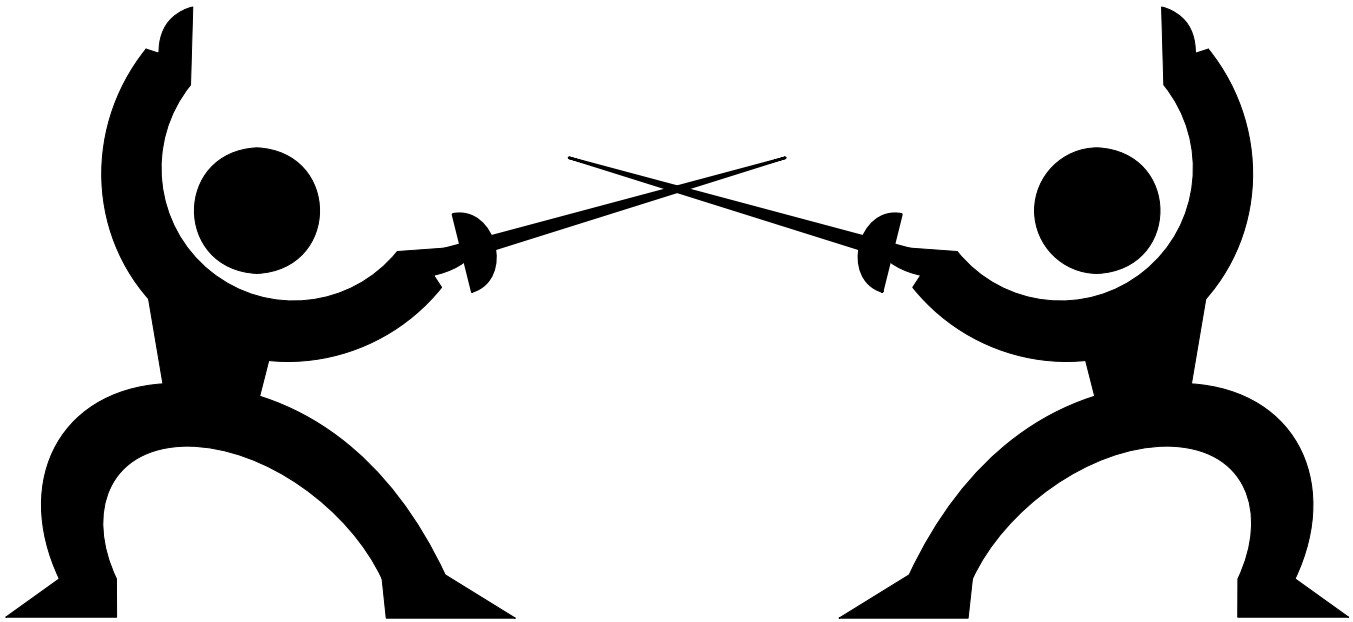
- **Send a Letter of Interest describing what makes your center special, i.e., different specialties, cutting-edge technology, location, etc.**
- **Request from MCO:**
  - **application**
  - **standard contract**
  - **fee schedule**
- **Provide MCOs with a list of commonly performed CPTs – request reimbursement rates**

MARKET YOUR ASC

- **Build relationships – have the plan representative tour your facility**
- **Demonstrate the value of your facility to the payor:**

Patient safety	**Staff experience**
Good outcomes	**State-of-the-art technology**
Low infection rates	**High pt satisfaction rates**
High surgical volume	**Physician qualifications**
Accreditation	**Low nurse-to-patient ratios**
Cost savings	

Know in advance what battles you need to win in contract negotiation – create areas for compromise – reciprocity is essential to successful negotiations



REVIEW

INITIAL REVIEW

- **Once a sample contract and reimbursement information is received, assemble a Review Team to include:**
  - **Administrator**
  - **Clinical Director**
  - **Medical Director**
  - **Business Office Coordinator**
  - **Governing Body**
  - **Healthcare Attorney, if applicable**

BUSINESS TERMS

- **Make sure contract has language identifying terms such as:**
  - **Member**
  - **Clean Claim**
  - **Covered Service**
  - **Payment Policies**
- **Establish multiple procedure discount**
- **Make sure there is no limit on number of procedures per case**
- **Determine reimbursement rates for more complex procedures, i.e., discectomies, laparoscopic procedures, etc.**

BUSINESS TERMS

- **For reimbursement based on percentage of Medicare rates, make sure percentage is appropriate for your market**
- **If reimbursement based on percentage of usual and customary rates, request copy of UCR schedule**
- **If reimbursement based on MCO-devised fee schedule, request copy**

BUSINESS TERMS

- Have coder or someone familiar with Medicare groupers analyze proposal to determine whether CPTs are linked to the same groups and reimbursement structure
- May have to move high cost procedures to higher reimbursement group
- Ask how CPT codes which do not have an assigned group are paid
- Identify all procedures to be done at ASC and ascertain coverage/reimbursement

BUSINESS TERMS

Avoid unfavorable terms:

- **MCO definition of "cases" – other fees may be included in fee, i.e., anesthesia/surgeon**
- **Termination, rate changes, amendments by written notice only – demand the right to negotiate**
- **Maximum reimbursement clauses, i.e., caps**
- **Must submit annual financial statements**
- **Allowance for automatic fee decrease if CMS fee schedule changes**

Sample Contract Language You May Encounter

These examples have been selected from actual contract proposals

The names have been changed to protect the guilty

LEGAL TERMS

- **<u>Ancillary Provider Charges</u> – must notify carrier 30 days in advance of fee schedule changes - *what happens if you don't?***

- **<u>Submission of Claims</u> – 90 days to submit claims – *request 365 days as allowed by Medicare.***

- **<u>Plan Payment Time Frame</u> – 90 days to pay "complete and accurate" claims:**
  - ***request claim payment in 30 days (check state prompt payment statute)***
  - ***request definition of "complete and accurate"***

LEGAL TERMS

- **<u>Emergency or Emergency Services</u> – most ASCs do not provide emergency services – *ask them to remove this clause***

- **<u>Most Favored Nation</u> – requires you notify carrier if you agree with another company to lower fees – they may be able to change your reimbursement rate to that lower rate – *ask them to remove clause***

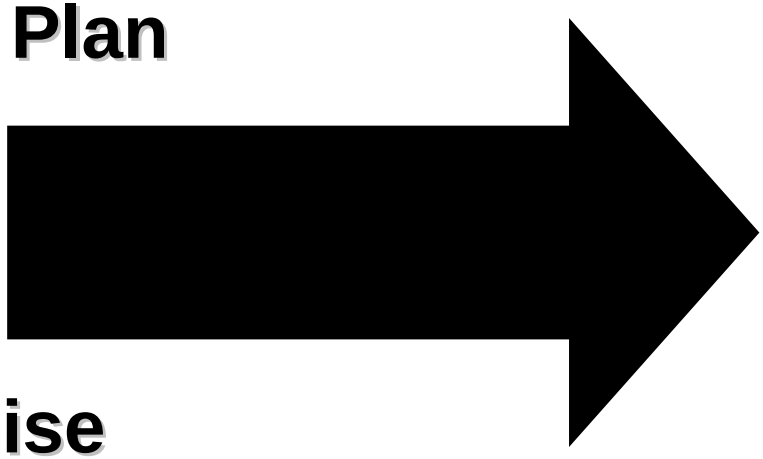
- **<u>Affiliate or Assignment Clauses</u> – carrier can determine which of their affiliates gets your contract – *clarify that facility may cancel contract with cause if affiliate not acceptable***

NEGOTIATION

READY, SET, GO

Always be:

- **prepared**
- **concise**
- **knowledgeable about ASC**
- **knowledgeable about Plan**
- **confident**
- **patient**
- **respectful**
- **prepared to compromise**
- **prepared to walk away**



REMEMBER

- **Important – get everything in writing (e-mail works great)**
- **When negotiating a contract, be sure that it is easily administered with simple reimbursement guidelines**
- **Smile in your voice**

INFORMATION TO HAVE READY

CREDENTIALING INFO THAT MAY BE REQUIRED BY MCO	
Legal Facility Name	Fee Schedule
Administrator/BOM Names	Fiscal Year End
Facility Address	List of Physician Providers
Phone and Fax Number	List of Physician Contracts
Medical Director	List of Specialties
Anesthesia Group	Pay to Address
Liability Insurance	Quality Assurance Policy
Medicare 855	Tax Identification Number, W-9
Medicare Certification	Website, if applicable
Liability Coverage	Letter of Interest
State License	Provider Application
Proof of Accreditation	Credentialing Policy
Deficiencies, if applicable	Credentialing Application

NEGOTIATION CHECKLIST

Develop and utilize a checklist:

- Name of company
- Rate - how it pays
- Discount appropriate for market share
- Accreditation required
- Claim payment time
- Submission time
- Length of contract/renewal options
- How refunds are handled
- Percentage of caseload anticipated

QUESTIONS TO ASK

- **Legal name of company, address?**
- **What is the contracting procedure?**
- **How long will the process take?**
- **How long is credentialing; load time?**
- **What is required to contract?**
- **What is reimbursement schedule based on?**
- **What method was used to devise schedule?**
- **If based on Medicare groups or APCs, how are zero groupers reimbursed?**

QUESTIONS TO ASK

- **Will you send copy of fee schedule?**
- **How many ASCs are in your network?**
- **Do you allow all ASCs in that apply?**
- **Do you allow silent PPOs to access?**
- **What product lines do you offer?**
- **Which ones will we participating in?**
- **Do you function as a complementary network?**

QUESTIONS TO ASK

- **How are multiple procedures paid?**
- **How are implants paid?**
- **Plan definition of implant versus supply?**
- **Is there an implant reimbursement threshold (cumulative or each)?**
- **How are other ancillary procedures paid (drugs, biologicals, x-rays)?**
- **How are new procedures/technology paid?**

QUESTIONS TO ASK

- **Claim submission requirements?**
- **How are multiple procedures billed - individual lines or rolled into primary?**
- **Timely filing clauses?**
- **How many days to payment?**
- **What is the time frame for:**
  - **appeals?**
  - **recoup payments?**
- **Do they allow out-of-network discounts to plan-holders during contract negotiations?**

CARVE-OUTS

- **Concentrate on need for carve-outs for cases that require:**
  - **Extra time**
  - **Expensive equipment or instruments**
  - **Additional staffing**
  - **Extra supplies and expensive packs**
  - **Expensive implants – negotiate for at least cost plus shipping**

CONTRACTING TIPS

- **Most companies limit the number of carve-outs – so be sure you concentrate not only on expense, but also the most commonly performed procedures**
- **Evaluate the possibility of having some expensive procedures reclassified to a higher reimbursement group**
- **When negotiating implant coverage, ask if invoice must be submitted with claim**

CONTRACTING TIPS

- **Include plan penalties for late payments**
  - **Interest – high enough that they want to pay you first**
  - **Penalties such as loss of the contract rate discount**
- **Include prompt payment clauses that follow state regulations and are enforceable**
- **Understand timely filing deadline**

CONTRACTING TIPS

- **If your state charges sales tax on medical services, request plan pay those taxes**
- **Address retaining higher reimbursement rate should managed care organization merge**
- **Avoid boiler-plate contracts – your contract should address your specific needs**

EXECUTION

FINAL STEPS

- **Request an electronic copy of the proposed plan –this can speed negotiations and clarify requested changes**
- **Highlight areas that you don't understand - ask for explanations**
- **Read contract thoroughly before signing**
- **Be sure negotiated changes are included in the final contract**
- **If applicable, have reviewed by your healthcare attorney**

Congratulations – you are a Participating Provider!

MANAGEMENT

NOW THAT YOU HAVE THE CONTRACT…

- **Once you have negotiated the best contract possible, be sure to share this information with your staff**
- **Provide a managed care matrix outlining each contract to schedulers, coders, billers**
- **Load contract into your software system, including all carve-outs, extras, etc.**
- **Periodically review reimbursement terms and renegotiate when applicable or when adding new services**

AUDIT REIMBURSEMENT

- Make sure the payor reimburses properly
- Check each EOB against your contract matrix for accuracy of reimbursement
- Determine if payment was received within time period defined by contract
- Appeal all incorrect reimbursements
- Remember compliance works both ways - be sure your billing department is following terms of contract when submitting claims

Additional Tools & Resources

Median Costs for Hospital Outpatient Services, by HCPCS code - SAMPLE ONLY
2008 Cost Info: The data are based on claims for hospital outpatient services provided January 1, 2006 through December 31, 2006.

HCPCS Code	Description	HOPD National Payment Rate	Mean Cost	"True" Median Cost
19101	Biopsy of breast, open	$ 1,314.75	$ 1,229.17	$ 1,173.20
19102	Bx breast percut w/image	$ 453.16	$ 549.96	$ 443.54
19103	Bx breast percut w/device	$ 864.74	$ 972.06	$ 864.16
19110	Nipple exploration	$ 1,314.75	$ 1,439.65	$ 1,342.88
19112	Excise breast duct fistula	$ 1,314.75	$ 1,365.75	$ 1,308.85
19120	Removal of breast lesion	$ 1,314.75	$ 1,302.40	$ 1,231.90
19125	Excision, breast lesion	$ 1,314.75	$ 1,594.13	$ 1,498.01
23120	Partial removal, collar bone	$ 1,859.23	$ 2,027.22	$ 1,893.70
23125	Removal of collar bone	$ 1,859.23	$ 1,791.05	$ 1,783.07
23130	Remove shoulder bone, part	$ 2,737.89	$ 2,348.85	$ 2,227.84
23140	Removal of bone lesion	$ 1,354.70	$ 1,466.79	$ 1,447.10
23410	Repair rotator cuff, acute	$ 2,737.89	$ 3,148.54	$ 2,916.67
23412	Repair rotator cuff, chronic	$ 2,737.89	$ 3,166.21	$ 2,905.15
23415	Release of shoulder ligament	$ 2,737.89	$ 2,821.06	$ 2,524.25
23420	Repair of shoulder	$ 2,737.89	$ 3,188.66	$ 2,882.11
23430	Repair biceps tendon	$ 2,737.89	$ 2,905.75	$ 2,559.75
25805	Fusion/graft of wrist joint	$ 2,737.89	$ 4,633.65	$ 4,643.57
25810	Fusion/graft of wrist joint	$ 5,058.86	$ 4,198.89	$ 3,820.22
25820	Fusion of hand bones	$ 1,048.64	$ 3,447.31	$ 3,495.30
25825	Fuse hand bones with graft	$ 5,058.86	$ 3,923.35	$ 3,541.03
25830	Fusion, radioulnar jnt/ulna	$ 5,058.86	$ 3,207.93	$ 3,029.07
26110	Biopsy finger joint lining	$ 1,048.64	$ 1,283.64	$ 1,314.53
26115	Removal hand lesion subcut	$ 1,344.57	$ 1,126.49	$ 1,061.69
26116	Removal hand lesion, deep	$ 1,344.57	$ 1,210.26	$ 1,139.93
27446	Revision of knee joint	$ 17,494.93	$ 15,129.66	$ 17,272.28
27605	Incision of achilles tendon	$ 1,326.64	$ 1,175.85	$ 1,087.85
27606	Incision of achilles tendon	$ 1,354.70	$ 1,620.37	$ 1,480.19
28289	Repair hallux rigidus	$ 1,326.64	$ 1,921.73	$ 1,680.74
28290	Correction of bunion	$ 1,873.67	$ 1,691.17	$ 1,519.35
28292	Correction of bunion	$ 1,873.67	$ 1,802.42	$ 1,651.09
28293	Correction of bunion	$ 1,873.67	$ 2,831.94	$ 2,592.91
28294	Correction of bunion	$ 1,873.67	$ 1,915.57	$ 1,610.14
28296	Correction of bunion	$ 1,873.67	$ 2,047.09	$ 1,897.50
28297	Correction of bunion	$ 1,873.67	$ 3,048.90	$ 2,820.02
28298	Correction of bunion	$ 1,873.67	$ 1,953.25	$ 1,857.51
28299	Correction of bunion	$ 1,873.67	$ 2,111.25	$ 1,968.55
28300	Incision of heel bone	$ 2,819.65	$ 2,427.37	$ 2,121.63

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