The New Look of Healthcare Reimbursement: Narrow Networks, Bundled Payments & Price Transparency

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Overview

- Understanding narrow networks
- Identifying narrow network language in managed care contracts
- Examining bundled payments
- Discussing price transparency


Narrow Networks

History and Evolution of Narrow Networks

- Referrals
- HMO/PHO/MCO
- Centers of excellence
- Employer direct contracting
- Tiered categories

Different Types of Narrow Networks

- HMOs
- Exchange products
- Low cost
- High performance network
- Centers of Excellence

Why the Growth in Narrow Networks?

- Cost Containment
  - Surgery-related costs represent 30% of the total U.S. healthcare spend
    - Employers, patients and payors are leading the charge to reduce costs
    - Better outcomes
    - Fewer bills
  - More than 82% of employers (500+ employees) choose self-funded plans
  - 29 states self fund all of their health plans, and 48 currently self-fund at least one of their state employee health plans*

* Milliman Atlas of Public Employer Health Plans

How to Identify a Narrow Network Patient

- Run an eligibility report, call for benefits, give facility information and verify your status with that carrier
- Insurance verification will identify tier structures and other narrow network information
- Patients may not be eligible for benefits in your ASC even if you are participating with the plan

Narrow Network Language in Managed Care Contracts

Narrow Network Language: Specialty Products

Product Participation

Company reserves the right to introduce and offer facility's participation in new Specialty Programs and products during the term of this Agreement and will provide facility with written notice of such new Specialty Programs and the products associated compensation.

Nothing herein shall require that Company identify, designate or include Facility as a preferred participant in any specific Specialty Program or product; provided, however, facility shall accept compensation in accordance with this Agreement for the provision of any Covered Services to Members under a Specialty Program or product in which Facility has agreed to participate hereunder.

Company may sell, lease, transfer or otherwise convey to payers (other than Plan Sponsors) which do not compete with Company's product offerings (e.g., workers' compensation or automobile insurers) in the geographic area where Facility provides Covered Services, the benefits of this Agreement, including, without limitation, the Services and Compensation Schedule attached hereto, under terms and conditions which will be communicated to Facility in each such case.

- Introduction/offer of Specialty Programs (state employee, self funded, etc.)
- Nothing shall require that Company identify, designate or include facility as a preferred participant in any specific Specialty Program or product.
- Company can sell, lease, transfer

Narrow Network Language: Payment Responsibility

Company Obligation to Pay for Covered Services.
Company agrees to: (a) pay Facility for Covered Services rendered to Members of Full Risk Plans, and (b) notify Plan Sponsors to forward payment to Company for payment to facility for Covered Services rendered to a Plan Sponsor's Members, according to the lesser of (1) Facility's actual billed charges or (1) the rates set forth in the Services and Compensation Schedule, within thirty (30) days or such time as permitted by applicable law or regulation of actual receipt by Company of a Clean Claim.

While Company may pay claims on behalf of Plan Sponsors, Facility and Company acknowledge that **Company has no legal responsibility for the payment of such claims** for Covered Services rendered to a Plan Sponsor's Members; provided however, that Company agrees to reasonably assist facility as appropriate in collecting any such payments

- Carrier is only responsible for paying claims for fully insured plans
- Carrier is only required to notify Plan Sponsor and will "reasonably assist facility with collecting payments"

Narrow Network Language: Restricting Ability to Participate

Other Payors

Payor may contract with employers, insurance companies, associations, health and welfare trusts, or other organizations to provide administrative services for plans provided by the entities that are not underwritten by Payor (including both local and Payor Accounts Programs).

Interference with Contractual Relations

Facility shall not engage in activities that will cause Company to lose existing or potential Members, including but not limited to: (a) advising Company customers, Plan sponsors or other entities currently under contract with company to cancel, or not renew said contracts; (b) impeding or otherwise interfering with negotiations which Company is conducting for the provision of health benefits of Plans; or (c) using or disclosing to any third membership lists acquired during the term of this Agreement for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company.

Impact of Narrow Network on Your Surgery Center

- Typically lower reimbursement
- May have additional credentialing requirements
  - If not credentialed, won't get paid
- Could be excluded from narrow network without knowing it
  - Need to understand how you are rated / tiered / center of excellence or not, etc.
- Narrow networks may have bundled payment arrangements
  - Need to be prepared to handle bundled payments
- ASCs could benefit from potential additional volume from being part of select narrow networks

Bundled Payments

Bundled Payment Trends

- 97% of health plans and hospitals are using a complex mix of value based and fee-for-service reimbursement
- Bundled payments are the fastest growing value based payment model and will account for 17% of all reimbursement in the next 5 years

What's Bundled in the Payment

Possible Included (but not limited to) Services

- Surgical episode on date of service (DOS)
- Surgeon fees
- Physician assistant fees- medical or PA (if applicable) reimbursement provided by the primary surgeon
- Facility fees
- Anesthesia fees
- Ancillary services on the DOS, (e.g. labs; radiology; pathology; neuro-monitoring services; and implants)
- Physical therapy
- All post-surgical exams and treatment during the global period
- All fees associated with the episode of care

Bundled Payment Companies and Managed Care Contracts

Example provider manual

ASC personnel shall identify potential Bundled Payment Patient through verification of:

1. Carrier PPO Plans
2. Primary CPT Code in contract
    a. Once the case has been identified as bundled, please submit the following documents to bundled payor
    - Signed carrier form
    - Patient demographics
    - Copy of patient insurance card
    - Authorization (if applicable)

3. ASC submits documents via email/fax **including carrier payment form** to….

Plans that may NOT qualify:

- Federal Gov't
- HMO Plans
- Patient with secondary coverage

- Difficult to identify who qualifies as a bundled payment patient

Bundled Payment Agreement

Bundled Payment Agreement: ASC acknowledges that it is a party to an agreement with “Bundled Payment Company” pursuant to which ASC has agreed to accept payment for certain ASC Services directly from “Bundled Payment Company.” In exchange for ASC Services that are also “Bundled Payment Company Services,” ASC shall accept payment in accordance with the contract between “Bundled Payment Company” and ASC, in lieu of the payor reimbursement.


Price Transparency

Patient as a Payor

- Patients are now being required to pay higher premiums, deductibles and co-payments
  - Employee contributions have increased by 83% over the past 10 years
- Historically patient responsibility represented 10% of total revenue
  - Today it's 21% and growing
- Patients today are highly informed consumers
- Numerous sites now exist that provide healthcare pricing information
- The end goal is to ultimately protect consumers from large medical bills and high utilization
- States are enacting surprise billing laws and mandatory price transparency for health care providers
  - However, 43 states recently received a failing grade by the 2016 Report Card on State Transparency Laws

*KFF 2015-2016 Employer Health Benefits Survey

Surprise Billing Law

Example: California Health and Safety Code

- Approved by Governor – September 23, 2016
  - (a) (1) Except as provided in subdivision (c), a health care service plan contract issued, amended, or renewed **on or after July 1, 2017** shall provide that if an enrollee receives covered services from a contracting health facility at which, or as a result of which, the enrollee receives services provided by a non-contracting individual health professional, the enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from a contracting individual health professional. This amount shall be referred to as the "in-network cost-sharing amount."
  - The plan shall reimburse the greater of the average contracted rate or 125 percent of the amount Medicare reimburses

Surprise Billing Law (cont.)

Example:California Health and Safety Code

- (e) (1) A non-contracting individual health professional may **advance to collections only the in-network cost-sharing amount**, as determined by the plan pursuant to subdivision (a) or the out-of-network cost-sharing amount owed pursuant to subdivision (c), **that the enrollee has failed to pay**
- (2) The non-contracting individual health professional, or any entity acting on his or her behalf, including any assignee of the debt, **shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for a minimum of 150 days after the initial billing** regarding amounts owed by the enrollee under subdivision (a) or (c).
- (3) With respect to an enrollee, the non-contracting individual health professional, or any entity acting on his or her behalf, including any assignee of the debt, **shall not use wage garnishments or liens on primary residences** as a means of collecting unpaid bills under this section.

Price Transparency: Florida Transparency Law

1. Price transparency legislation sets a new standard for patients. In the past, receiving an unexpected medical bill (or a bill for an unexpectedly high amount) may have been acceptable

- Patients are shouldering more of their care costs; therefore, they're paying more attention to their medical bills
- Consequently, they may have more questions regarding care costs, or they might be unwilling to pay a "surprise" bill

2. Patients are newly empowered, but they'll also have a lot of questions for you

- Even though patients will be able to access price-related data, you're still their care provider–and they trust you more than they trust a website
- You'll likely get more questions from patients, not fewer, because they'll want your help and confirmation as they review data.

3. Not every patient wants to price shop.

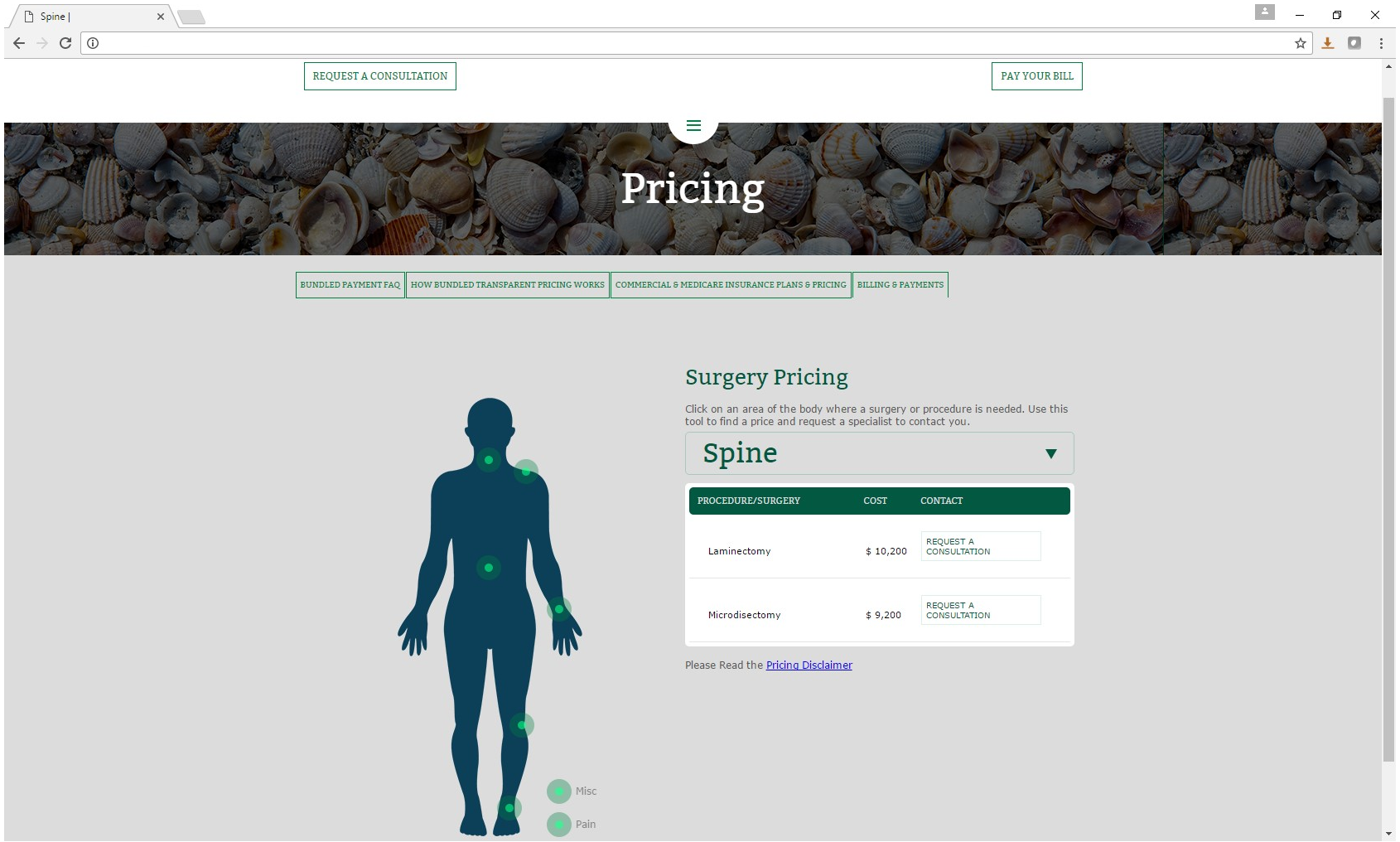
- They don't want to compare pricing; their priority is getting a credible estimate, understanding their payment responsibility and moving forward as quickly as possible

4. Change won't happen overnight.

- In Florida, state officials plan to launch a website with healthcare information that will allow patients to compare pricing and make informed decisions about their care plans
- While pricing websites are in progress, physician practices and other healthcare organizations can help patients by providing price transparency

http://dailypracticeblog.com/4-things-you-should-know-about-floridas-new-price-transparency-law/

Price Transparency: Florida Transparency Law (cont.)



Discussion

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