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Managed Care for Rehab Providers Made Easy

Mastering Contracts and Obtaining Fair Reimbursement

Contents

CHAPTER 2

Insurance—where it all begins

Why managed care? Probably the biggest reason that care is managed today is to manage costs. In fact, many people jokingly refer to managed care as managing costs. Most rehab providers in aggressively managed markets have come to think that all managed care is about is managing costs.

In this chapter, we will take a look at the different types of managed care plans, from group health to Medicare and workers' compensation. There may be variations in managed care arrangements from market to market, in addition to insurance regulatory requirements in your state.

There are some other reasons for managing care, which include the following:

- Provide better, more uniform standards of care. Throughout the world of managed care, we've learned about disease management, critical pathways, and uniform standards of treatment. In fact, as therapists, we are all familiar with standards of care in our own professions.

- Ensure that the patient gets the best care and the most appropriate care for the best investment for the managed care plan.

- Simply, "it's the right thing to do."

Why manage costs?

The two largest payers of healthcare in our country today are the federal government and employers who provide health insurance coverage for their employees. The government is concerned about the solvency of the Medicare Trust Funds. The impetus for the Balanced Budget Act of 1997, which put all of the rehab community on a fee schedule and a cap on services, was to secure solvency of the Medicare system for generations to come. (MCOL, 2007)

Employers are concerned about the inflationary nature of health insurance premiums. Most employers that provide health insurance coverage subsidize this coverage for their employees. In other words, employees have been shielded from the inflationary rates.

Managing costs has simply become a matter of good business, not only for the government but for the employers as well. As taxpayers, we have consistently encouraged our representatives in Washington to lower our taxes. As employees, we have consistently encouraged our employers to keep our health insurance premiums low and affordable.

How did we get here?

The Managed Care Museum (an online resource on managed care) provides us with the following timeline, as noted in Figure 2.1 (MCOL).

F I G U R E 2.1 MCOL

THE HISTORY OF MANAGED CARE

1917

– Western Clinic in Tacoma provides prepaid physician services for the lumber industry. (3)

1929

– Dr. Justin Ford Kimball at Baylor Hospital in Texas establishes The Baylor Plan, a prepaid hospitalization plan that first uses the Blue Cross logo. (3)

– Ross-Loss prepaid medical clinic started by Drs. Donald Ross and H. Clifford Loss under contract with Los Angeles Department of Water and Power for its employees. (1)

– Rural Farmers' Cooperative Health Plan started by Michael Shadid in Elk City, OK. (1)

1933

– Sidney Garfield, MD, establishes prepaid plan to fund care for his Contractors General Hospital and clinic, which provides care to workers on Los Angeles Aqueduct. (2)

1937

– Group Health Association (GHA) started in Washington, DC, to serve employees of Federal Home Loan Bank. (1)

FIGURE 2.1 (CONT.) MCOL

1938

– Henry J Kaiser recruits Dr. Garfield to establish prepaid clinic and hospital care for his Grand Coulee Dam project in Washington State. (2)

1939

– Blue Shield program adopted for participating prepaid physician plans. (3)

1942

– At the request of Henry Kaiser, Dr. Garfield expands program to Kaiser-managed shipyards and Kaiser steel mill. (2)

1945

– Group Health Cooperative of Puget Sound established in Seattle, WA (1)

– Permanente Health Plans opens to the public in California, in addition to serving Kaiser employees. (2)

1947

– American Medical Association (AMA) indicted and convicted of antitrust violations due to organized efforts to curb physician participation with Group Health Plans. (1)

– Health Insurance Plan (HIP) of Greater New York established to serve New York City employees. (1)

1949

– 81 Blue Cross hospital Plans and 44 Blue Shield medical Plans cover 24 million Americans. (3)

1952

– Permanente Health Plans changes name to Kaiser, while the medical group retains the Permanente name. Kaiser membership at 250,000. (2)

FIGURE 2.1 (CONT.) MCOL

1954

– First IPA, the San Joaquin Medical Foundation, is formed in California. (1)

1955

– Kaiser expands to Oregon, and total membership reaches 500,000 (2)

1958

– Kaiser expands to Hawaii. (2)

1959

– Blue Cross Companies cover 52 million and Blue Shield Plans cover 40 million Americans. (3)

1963

– Kaiser membership reaches 1 million. (2)

1968

– Kaiser expands to Colorado and Ohio. (2)

1970

– Paul Ellwood coins the term "Health Maintenance Organization". (1)

1973

– HMO Act of 1973 signed into law by President Nixon, using federal funds and policy to promote HMOs. (1)

1976

– Kaiser membership reaches 3 million. (2)

1979

– Blue Cross Blue Shield collectively covers 87.4 million Americans. (3)

1980

– Kaiser expands to Mid-Atlantic region. (2)

FIGURE 2.1 (CONT.) MCOL

1981

– Kaiser membership reaches 4 million. (2)

1982

– California legislation enacted allowing selective contracting for Medicaid and private insurance, paving the way for other states to enact similar laws facilitating Preferred Provider Organizations (PPO). (5)

– The Tax Equity and Fiscal Responsibility Act (TEFRA) makes it easier and more attractive for HMOs to contract with the Medicare program. (4)

1985

– National total HMO enrollment reaches 19.1 million. (6)

1990

– National total HMO enrollment reaches 33.3 million. (6)

– National PPO enrollment surpasses HMO enrollment with 38.1 million members. (6)

– NCQA established. (7)

1991

– HEDIS 1.0 released. (7)

1994

– Blue Cross Blue Shield Association eliminates requirement that all Member Plans must maintain not-for-profit status. (3)

1995

– National total HMO enrollment reaches 50.6 million. (6)

1996

– Health Insurance Portability & Accountability Act of 1996 (HIPAA) includes patient privacy compliance and health plan portability provisions. (4)

F I G U R E 2.1 (CONT.) MCOL

1999

– NCQA initiates accreditation of PPOs, which now cover 89 million Americans. (7)

2000

– National total HMO enrollment is 80.9 million, declining for the first time from the previous year's level (81.3 million in 1999). (6)

2003

– Medicare Modernization Act establishes Part D drug benefit, establishes HSAs, renames Medicare+Choice program to Medicare Advantage, and increases payment rates to Medicare Advantage plans. (4)

2004

– National total HMO enrollment is 68.8, and national PPO enrollment is 109 million. (6)

2006

– National total HMO enrollment is 67.7, and national PPO enrollment is 108 million. (6)

– Medicare Part D prescription benefit becomes effective.

(Resources: (1) Tufts Managed Care Institute, "A Brief History of Managed Care" (2) Kaiser Permanente, "History of Kaiser Permanente" (3) Blue Cross Blue Shield Association "Blues History" (4) Centers for Medicare and Medicaid Services, "Key Milestones in CMS Programs" (5) California Health Care Foundation, "Making Sense of Managed Care Regulations in California" (6) MCOL Managed Care Fact Sheets (7) NCQA Timelines)

Source: MCOL's Managed Care Museum. http://www.managedcaremuseum.com

Managed care penetration varies by market across the country, and the end-of-the-year managed care statistics for 2006 are noted in the map on the CD-ROM.

Managed care usually involves the following three key components:

1. **Care management:** Oversight and management of the medical care that is given

2. **Contracts:** Contractual relationships with the providers who provide the care

3. **Benefit design:** Covered benefits based upon the managed care plan and its rules

These components are organized into various formats and designs of managed care plans available in the marketplace today. For example, an HMO in your market may offer several different types of managed care products, as well as custom products designed for large employers based upon the book of benefits that the employer wants to offer its employees. Alternatively, it may be required to offer under a collective bargaining agreement.

Insurance and managed care products

President Richard Nixon signed into law the HMO Act of 1973. The Act provided for grants and loans to start health maintenance organizations (HMO). One of the newest movements in the health insurance market today is called "consumer directed healthcare." This term applies to a variety of health plan designs, most notably the HSA—the Health Savings Account–type plan that is a combination of a high-deductible health insurance plan accompanied by an employer-

administered pre-tax savings account. This is making health insurance more affordable, particularly in the small employer market. The employee or individual meets a high deductible (e.g., $5,000) and pays for healthcare expenses out of a HSA or a health reimbursement account that is funded with pre-tax dollars. When the high deductible is met, reimbursement according to the benefit plan design kicks in, including any co-pays.

Indemnity plan

An indemnity plan is a traditional health insurance plan that was first offered before managed care began. Indemnity plans provide coverage for all healthcare services from any provider that the enrollee chooses. Payment to providers under indemnity plans is based on the average charges in the area where the provider practices (Usual Customary and Reasonable charge), and the enrollee must pay a percentage of the cost of care, most often as an 80/20 split.

Health maintenance organization (HMO)

An HMO is defined as a prepaid plan that provides healthcare to enrolled members in return for a preset amount of money on a per member per month (PMPM) basis (capitation). They also may include plans that may not use prepayment but that place at least some of the providers at risk (under capitation) and use primary care physicians as gatekeepers.

There are two main types of HMO models in the marketplace:

1. **Staff Model HMO—**The doctors and other medical personnel are employees of the HMO, and they practice in clinics that are owned by the HMO.

2. **Group Model HMO—**The physicians are not employed by the HMO, and

they may be in independent or group practices that are under contract to the HMO. Additionally, there may be a mixed model type of HMO in which both a group model and staff model exist.

Preferred provider organization (PPO)

A PPO is a managed care plan that contracts with independent providers at a discount for services. The panel (or network) of providers is limited in size and usually has some type of utilization review system associated with it. This type of plan may be sponsored by an insurance company or another entity that only offers network services and contracts with payers or risk-bearing entities to provide benefit coverage.

PPO members get better benefits when they use the PPO's network of healthcare providers. They pay higher out-of-pocket costs, and may be subject to a deductible (or higher deductible) when they choose to go outside the PPO network.

Integrated delivery system (IDS)

An IDS is a complete selection of healthcare providers and their services, from primary care and specialty physician visits to wellness services through hospital inpatient care, as well as various ancillary services. This network is then offered to managed care plans providing efficiency and administrative ease in contracting. An IDS receives the money from managed care plans with covered lives (via capitation arrangements) and then subcontracts to other providers (e.g., rehabilitation facilities).

Physician hospital organization (PHO)

In contrast to an IDS, a PHO is the marriage of the hospital and its physicians that is developed for the purpose of contracting with managed care plans.

Management services organization (MSO)

In an MSO model, a management services organization provides services to physicians, which alleviates the burden of the operational management physician practices. The services include claims management, office administration and staffing, and managed care contracting. There are also groups organized in this fashion to provide assistance to outpatient physical practices and networks.

Independent practice association (IPA)

An IPA is an organization that has a contract with a managed care plan to deliver services in return for a single capitation rate. In return, the organization contracts with individual providers to provide services either on a sub-capitation basis or a discounted fee-for-service basis.

Selected service carve out entities

These companies specialize in providing a network of specialty providers to managed care plans (such as HMOs). Typical services include the following:

- Vision care
- Radiation oncology
- Mental health
- Rehabilitation

Larger managed care plans have moved to creating subsidiary organizations to do specialty contracting, and a competitive managed care plan may even contract with the subsidiary to provide a specialty network to their enrollees.

Exclusive provider organization (EPO)

An EPO is a managed care plan that is similar to an HMO in that it often uses primary care physicians as gatekeepers, often uses capitation to reimburse

providers, and limits the number of providers in its network. Members enrolled in this plan must use network providers to have services paid. The main difference is that this type of plan is generally regulated under insurance statutes, not HMO regulations.

Point of service plan (POS)

A POS is a managed care plan in which members do not have to choose how to receive services (i.e., in a restricted network or out) until they need them. POS plans operate like HMOs for enrollees that stay within the provider network. Unlike HMOs, however, if an enrollee chooses to use a provider outside the network, the services are covered, but with a greater cost share paid by the enrollee.

All of these entities—with the exception of indemnity plans—usually have one common importance to the rehabilitation provider: covered lives or plan members. The rehab therapy clinic may find themselves negotiating for their services with any one of these entities. Typically, the entities that have a greater control over service utilization, such as the HMO, will have the stronger negotiating position on price in the market.

Medicare managed care

A Medicare HMO is an HMO that has contracted with the federal government under the Medicare Advantage program (formerly called Medicare+Choice) to provide healthcare benefits for eligible Medicare beneficiaries who elect to enroll in the Medicare HMO, instead of receiving their benefits and care through the traditional fee-for-service Medicare program. There is an annual open enroll-

ment for these plans, but the members may opt out of the program at any time and return to traditional Medicare coverage.

Medicare Advantage Plans are health plan options that are approved by Medicare but run by private companies. They are part of the Medicare Program and are sometimes called "Medicare Part C." When Medicare beneficiaries join a Medicare Advantage Plan, they are still in Medicare.

According to information provided by Medicare (*www.medicare.gov*), some of the Medicare Advantage Plans require referrals to see specialists. In many cases, the premiums or the costs of services (copays and deductibles) can be lower than they are in the Original Medicare Plan or the Original Medicare Plan with a supplemental Medigap policy.

Medicare Health Plans charge different premiums and have different costs of services. These plans provide all of your Part A (hospital) and Part B (medical) coverage and must cover medically necessary services. Medicare managed care plans often have physician, hospital, and ancillary provider networks. Seniors must see doctors who belong to the plan or go to network hospitals to get covered services.

They generally offer extra benefits, and many include prescription drug coverage. In many cases, your costs for prescription drug coverage can be lower than in the stand-alone Medicare Prescription Drug Plans. Some of the plans coordinate care—using networks and referrals—more than others. This can help manage your overall care and can also result in savings to you. Beneficiaries who chose Medicare Part C don't need to buy a Medigap policy.

In areas of high senior population, Medicare managed care plans are highly competitive. They offer education sessions at local restaurants and compete with other managed care plans based on benefits that seniors are interested in. And, of course, they are hoping to enroll the seniors that jog on the beach.

Medicaid managed care

Medicaid is a partnership between the federal government and the states. Medicaid is available to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. Depending on the rules in your state, Medicaid recipients also may be asked to pay a small copayment for some medical services.

Medicaid is a state-administered program; therefore, each state sets its own guidelines regarding eligibility for services and the type of services that are in the benefit plan. According to a statistic posted at the Centers for Medicare & Medicaid Services (CMS) Web site, in 2004, the number of enrollees in Medicaid managed care was 27 million. Of the total Medicaid enrollment in the United States for that year, approximately 60% were receiving Medicaid benefits through managed care. All states except Alaska, New Hampshire, and Wyoming have some or all of their Medicaid population enrolled in a managed care organization. States can make managed care enrollment voluntary, or seek a waiver of section 1915(b) of the Social Security Act (the Act) from CMS to require certain populations to enroll in a Medicaid managed care organization, such as an HMO. Rehab providers specializing in pediatrics will most often encounter participation in a state's Medicaid managed care plan.

Workers' compensation managed care

Workers' compensation laws are designed to ensure that employees who are injured or disabled on the job are provided with medical indemnification and fixed monetary awards, eliminating the need for litigation. Workers' compensation laws also provide benefits for dependents of those workers who die due to work-related accidents or illnesses. State workers' compensation statutes establish this framework for most employment. Federal statutes govern benefits for workers, including the following:

- Postal workers
- Merchant marines
- Railroad employees
- Longshoremen
- Miners

Early forms of managed care in workers' compensation were really managed cost programs. These programs relied on state mandated fee schedules and a cottage industry that focused on claim review and re-pricing. Over the past decade, specialty managed care organizations have formed workers' compensation networks of providers that are willing to take discounts off of the discounted fee schedule, theoretically in exchange for volume.

Many states have passed legislation that limits the cost of medical services, including putting a cap on the number of services that an injured worker may receive with a detailed authorization process. This is challenging to physical therapy and rehab providers that specialize in providing therapy for injured workers, as well as work hardening and other return to work services.

According to the California Workers' Compensation Institute (CWCI), since the state of California has capped the number of physical therapy (and chiropractic) visits at 24, they have reported a 42%–45% decrease at the three month, six month, and nine month mark—in the average number of physical therapy visits since workers' comp reforms for physical therapy were instituted in 2004. The average claim costs for physical therapy decreased by an average of 47%–49% at the three month, six month, and nine month marks. (Source: CWCI, 2006)

In states where there is a mandated workers' compensation fee schedule, managed care organizations are emerging to form provider networks. For the privilege of joining the network, rehab providers are being asked to provide an additional discount on top of the already mandated discounted fee schedule imposed by the state.

Information regarding the workers' compensation laws in your state are most likely found on the official Web site of your state. The United States Department of Labor maintains a listing of workers' compensation laws by state, including medical benefits, at *www.dol.gov.*

In this chapter, we reviewed the key types of managed care plans present in the market place today, as well as an overview of the history of managed care. In your state, healthcare plans that are insurance products are regulated by the state; however, managed care networks, which are not insurance products, generally are not regulated by the state.

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