Managed Care Update:
Increasing Revenues in a Risk-Based World

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Where Are We Going?

You've got to be very careful if you don't know where you are going, because you might not get there.

Yogi Berra
Risks for Providers

- Patient Ineligible or Coverage is Unaffordable
- Coverage Gaps
- Unexpected Coinsurance Obligations
- Grace Periods for Premium Payments
- Provider Premium Subsidies
- Narrow and Tiered Networks
- Network Exclusion
Be Prepared!

Some 1,300 Rail Platforms Will Have to Be Trimmed at a Cost of $69 Million

By WILLIAM HOROBIN
May 21, 2014 11:50 a.m. ET
Qualified Health Plan

• The term “Qualified Health Plan” means a health plan that
  • provides the essential health benefits
    42 U.S. Code § 18021(a)
State & Federal Exchanges

- States may offer their own exchange or the federal government will operate the exchange for residents of their state.
  - 17 State-based exchanges
  - 7 Partnership exchanges
  - 27 Federally-facilitated exchanges

42 U.S. Code §18041(c)
State Health Insurance exchange Decisions, 2014

* In Utah, the federal government will run the exchange for individuals while the state will run the small business, or SHOP, exchange.

Patient is Not Eligible or Coverage is Unaffordable
Not Eligible for QHP

• These individuals are not eligible to purchase through the exchange:
  • Not a citizen or national of the United States or an alien lawfully present in the United States or is not reasonably expected to be for the entire period for which enrollment is sought. (42 U.S.C. §18032(f)(3))
  • Incarcerated individuals
    42 U.S.C 18032(f)(1)(B)
Cost of Coverage

• Cost of Premium May Still Be Too High
  • The national average premium for a 40-year-old individual purchasing coverage through the exchange is:
    • $270 per month for a silver plan and
    • $224 per month for a bronze plan
Coverage Gaps
The Coverage Gap

Figure 3

In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.

NOTE: Applies to states that do not expand Medicaid. In most states not moving forward with the expansion, adults without children are ineligible for Medicaid.
Unexpected Co-payment & Coinsurance Obligations
Co-pay & Coinsurance

• Patient Responsibility Based Upon Actuarial Value (coverage of benefits)
  • Bronze – 60%
  • Silver – 70%
  • Gold – 80%
  • Platinum – 90 %
  • Catastrophic Coverage
  • An individual could purchase coverage and still have a large coinsurance obligation.
Premium Tax Credits

- Citizens and legal residents in families with incomes between 100% and 400% of FPL are eligible for a tax credit to reduce the cost of coverage purchased on the exchange.
- Amount of tax credit varies with income
- Premium for second lowest cost silver plan would not exceed a specified percentage of their income
Grace Periods for Premium Payment
Grace Periods for Payment

• 90-Day Grace Period
  • QHPs must provide a grace period of 3 consecutive months if an enrollee who received payment of the premium tax credit paid at least 1 month’s premium.
  • QHPs must pay all allowable claims during the 1st month of grace period, but may pend claims in the 2nd and 3rd months.
Provider Premium Subsidy
Provider Premium Subsidy

• On Oct. 30, 2013, former Secretary Kathleen Sebelius stated in a letter that QHPs available in the exchanges are not “federal health care programs.”

• On Nov. 4, 2013, CMS issues a memo discouraging issuers from accepting third party premium payments for those enrolled in QHPs through the exchanges.
Provider Premium Subsidy

• On February 7, 2014, CMS issued yet another FAQ stating that the earlier FAQ did not bar payments by Ryan White programs, Indian organizations, or private charitable foundations.

• On March 11, 2014, CMS issued interim final rule with comment period requiring QHPs to accept premium and cost-sharing payment from Ryan-White, Indian Health, and other federal and state programs.
Provider Premium Subsidy

• Letter to the Secretary from the American and Catholic Hospital Associations requesting that CMS publicly reconfirm its February 7 statement.

• May 21, 2014 letter from the Secretary: “existing guidance related to third-party payments of premiums and cost sharing made on behalf of Marketplace QHP enrollees by private, not-for-profit foundations is sufficient ...such payments are not prohibited by HHS’s rules to the extent they are provided in a manner consistent with the February 7, 2014 FAQ.”
Narrow and Tiered Networks
Narrow Networks

• Pruning of networks is expected to continue
• "That's a trend I would expect with these rates," said Matt Eyles, executive vice president of the advisory firm Avalere Health.
• "The squeeze goes down to the providers."
Network Exclusion
ACA Non-discrimination

• A group health plan and a health insurance issuer offering group or individual health insurance coverage

• Shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law

42 U.S.C. §300gg-5(a)
Not Required to Contract

• This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer.

• Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures. 42 U.S.C. §300gg-5(a)
Exclusion Cases

• Challenges
  • Seattle Children’s Hospital
  • Frisbie Memorial Hospital
  • Fairfield County & Hartford County Medical Associations’ action to prevent UnitedHealthcare from terminating approximately 2,200 physicians from United’s Medicare Advantage program
Risk Continuum

• **Providers Take Risk in Many Ways**
  • Reform program results
  • Quality measures in bundled payments
  • Partial or condition-specific capitation
  • Full capitation with quality
  • Shared risk with quality
  • Fee-for-service with shared savings
  • Fee-for-service base pay plus pay for performance
  • Non-fee-for-service, non-visit function, eg. payment for care coordination or patient satisfaction rating
  • Non-fee-for-service shared savings
Don’t Be a Knucklehead
Reduce the Risk

• Take Action to Reduce Risks
  • Contracting
  • Before Non-Emergency Services
  • Are Provided
  • Dispute Resolution
Where Are We Going?

I have opinions of my own -- strong opinions -- but I don't always agree with them.

George W. Bush
References

- Ibid.
The New Revenue Boosters

Key Concepts:
• Quality as the Key
• Efficiencies
• Increase Capabilities to Accept Delegated Functions
• Collaborations and Partnerships
• The Shift to Retail
• Obtaining a Health Plan License
Why Quality Matters

“Quality is everyone’s responsibility.”

- W. Edwards Deming
Why Quality Matters

• Tiered and Narrow Networks
• Risk Pools and Shared Savings
• Leverage with Managed Care Organizations
• Transparency and Ratings
• “Age of Recommendation”
Ensuring Quality Within the Provider Organization

• By-Laws and Organizational Provider Contracts
  • Quality Management Requirements and Participation
  • Quality Measurements
  • Use of Data
  • Termination Provisions
  • Tiered and Narrow Network Provisions
Quality Requirements with Payers

• Specific Quality Measurements and Use of Data
• Define Outcomes
• Use of Data in Defining Different Networks
• Data Use in Shared Savings and Increased Reimbursement
• Ability to Challenge Data
Creating Efficiencies

• Lower Reimbursement Generally
• Expansion of Managed Care to Government Programs
• Private Equity Investments and Demands
• Who Does What -- Determine Relative Strengths with Partners
• Tighten Financial Oversight to Guard Against Overpayments and Recoupments
Increase Capabilities to Accept Delegated Functions from Payers

• Accepting More Delegated Functions for Increased Revenues and Control

• Use of Provider Managed Care Organization

• Payer Solvency Provisions
Collaborations and Partnerships

- Means by Which to Increase Efficiencies
- Need for Bundled Payments and Shared Savings
- Ancillary Providers
- Retailers
- Employers and Direct Contracting
- *Undertake Due Diligence on Potential Partners*
The Shift to Retail

• High Deductible Plans
• Health Benefit Exchanges
• Access and Consumer Convenience
• Advances in Equipment
• TeleHealth
• Consumer Learns to Drive
• Creating Loyalty to Maintain Patient Base
The Shift to Retail

• Transparency and Consumer Information

  • “The Medicare data ... provides an unprecedented look at the practice of medicine across the country .... It also provides consumers with an ability to compare doctors and treatments in a way they have never had until now.”*
  
  • From YELP Anecdotes to Factual Information
  • Price Disclosure and Competition
  • Quality Disclosure and Competition

* NY Times, April 9, 2014, page 1 (emphasis added; see references).
Think Retail

“Who are you

Who who who who”

-- The Who, Who are You album

• Your Data and Internet Reputation will Define You!
Think Retail

• Use Lessons from the Retailers
  • Convenience, Access and Value
  • Customer Services
  • Vision and Dental Experience
• Advertising
• Branding
• Customer Loyalty
Beware of the Round Hole

- Health Care Provider + Retailer = Square Peg in Round Hole
- Health Providers Subject to Different Marketing Playbooks
  - Professional Licensing Laws
  - Health Plan Laws
  - Government Program Restrictions
    - Federal Anti-Kickback and False Claims Laws (Walgreen’s, OIG Opinions)
Beware of the Round Hole

• Corporate Practice Restrictions
• State Referral Laws
• Unfair and Deceptive Advertising Laws
  • Price Disclosures
  • Comparative Advertising and Use of Data and Ratings
Assuring Compliance in the Retail World

- Educating the Field and Retail Partners
- Healthcare Compliance Program
- Protection through Contract Provisions
- Advertising Review Compliance Program
Obtaining a Health Plan License – Increasing Risk and Rewards

- Benefits Include:
  - Integration and Team Work for Efficiencies and Delivery of Health Care
  - Quality Improvement
  - In California, Avoids Corporate Practice Restrictions
  - Product Development and Bundling
Benefits Include:

- Increased Reimbursement as Health Plan or Downstream Provider Health Plan
- Referrals and Managed Care Contracting

**BUT, CAN BE COSTLY WITH START-UP AND ONGOING COMPLIANCE COSTS**
General References


• CalMediConnect: Managed Care for Dual Eligibles Fact Sheet, California Association of Health Plans, www.calhealthplans.org.


• Retail Medicine a Big Shift for 2014, HealthLeaders Media, January 6, 2014.


• Walgreens Pharmacy Chain Pays $7.9 Million to Resolve False Prescription Billing Case, Department of Justice, April 20, 2012, www.justice.gov/opa/pr/2012/April/12-civ-505.html

• Why insurers have no choice but to hire retail execs, Katie Bo Williams, Healthcare Dive, May 21, 2014.
• Offering Gifts and Other Inducements to Beneficiaries, Department of Health and Human Services Office of Inspector General, August 2002.
THANK YOU FOR LISTENING!!
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