



# Managing Payor Rates

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## PMI's 2024 Virtual Lunch & Learn

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### Topics Covered & Dates

Set Your Practice Fees

Wednesday, August 28, 2024

Practice Budgeting Tool

Thursday, September 5, 2024

Managing Payor Rates

Wednesday, September 25, 2024

Provider Margin Reviews

Wednesday October 9, 2024

Employed Provider Bonus Models

Wednesday, October 16, 2024


Split The Pot

Wednesday, October 23, 2024



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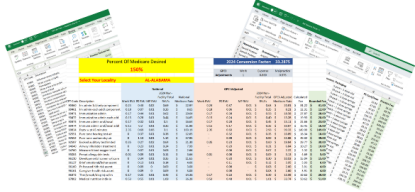
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## Setting Your Practice Prices

By Paul Vanchiere, MBA | Aug 28, 2024 8:04:04 PM

PM's presentation on "Setting Your Practice Fees" was broken into three parts for your convenience as each area relies on a specific set of data to help you properly set your practice fees for pediatric practices.


Check out the details below to find the most time-efficient way to properly set your practice fees/prices.






**Setting Your Vaccine Prices**

Video & resources for pediatric practices to set their vaccine pricing/fees.




**Setting Your Lab Services Prices**

Video & resources for pediatric practices to set their lab service prices/fees.




**Setting Your Professional Services Prices**

Video & resources for pediatric practices to set their professional services prices/fees.



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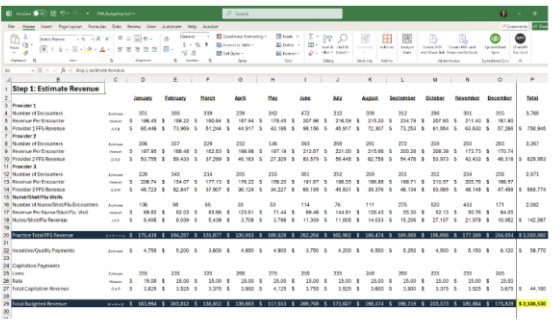

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## Pediatric Practice Budgeting

By Paul Vanchiere, MBA | Sep 5, 2024 9:13:05 AM

This presentation shared with pediatric practices an approach to preparing an annual budget.

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**WELCOME ALL!**

**Advanced Practice Management Webinar**

**Speakers:** Paul D. Vanchiere, MBA, Richard Lander, MD, FAAP, Chip Hart

**Moderator:** Dr. Naveen Mehrotra, NJAAP Practice Management & Pediatric Council Co-Chair

**Date/Time:** September 10, 2024 | 10 AM – 1:30 PM EST

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- Common Issues Seen In Pediatric Practices
  - Paulie Vanchiere
- Spend A Day Coding With A Pediatrician
  - Richard Lander
- Where Is Your Practice Losing Money?
  - Chip Hart



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**Special Thanks to Susanne Morgana-Brennan with IPMSO**

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# Drivers of U.S. Healthcare



### Past- Capitation & Women

- Pediatrics
- Obstetrics
- Gynecology
- Oncology



### Today- ACO's & Convenience

- Location
- Hours / Access
- Dual Income Families
- Children Having Children
- Cost- Larger Deductibles



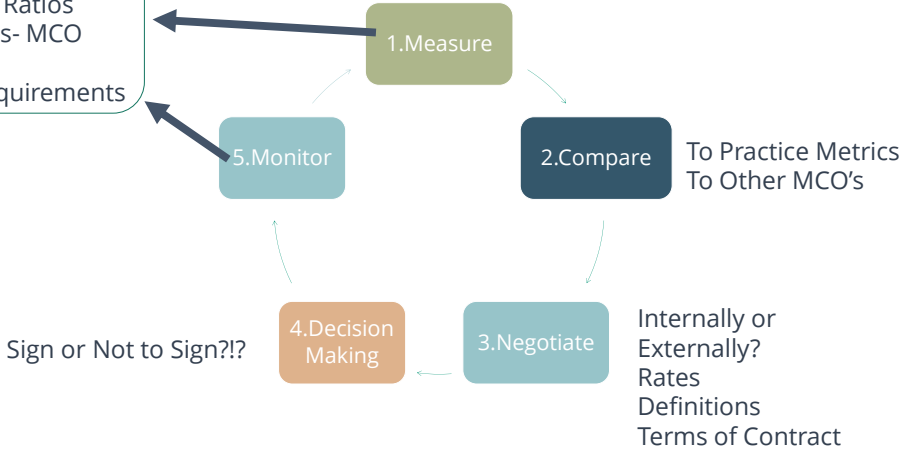
### Future- Quality & Convenience

- NCQA, PCMH, MACRA, MIPS



# Steps in MCO Negotiation

- 1. Denials
- 2. Gross & Net Collection Ratios
- 3. Operations- MCO Response
- 4. Admin Requirements





## Self Evaluation

**Competition**

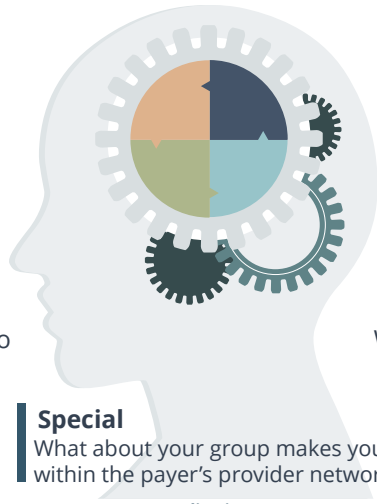
What separates you from your competition?

**Competitors**

What do you do clinically better than your competitors?

**Benefits**

What benefits do you bring to the hospitals you cover?



**Special**

What about your group makes you "special" within the payer's provider network?

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**Patients**

What are benefits to the patients you treat?

**Satisfaction**

In your opinion what is the level of patient satisfaction?

**Healthcare**

What do you do clinically that reduces healthcare costs for the payer?

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## MCO Objective

### Balancing Act:

- Income & Premiums
- Expenses & Claims
- Viable Panel

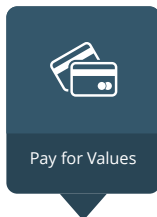


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## Perspectives: Payer



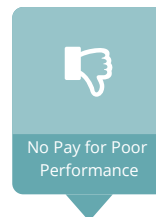
Moving away from fee-for-service models and paying for 'value' and 'outcomes'



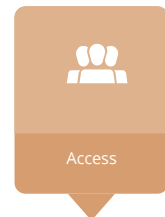
Increasing pressure from employers to provide value and quality-based programs and networks



Development of 'value based' contracts that include pay for performance (P4P), meeting targets to 'earn' incentives, per member per month (PMPM) stipends for coordinating care



Rapidly moving toward no-pay-for-poor-performance (e.g. CMS 'value modifier')



Access to certain consumers / patients based on performance, in the form of tiered networks (e.g. United Healthcare's Tier 1 program)

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## Perspectives: Employer



✓ Moving away from premium-based insurance to 'self-funded' programs

✓ Self-funded insurance presents risk (all claims need to be paid by employer) and opportunity (driving benefit design and coverage)

✓ Seeking 'direct care' opportunities with primary care and specialist care (e.g. the Whole Foods contract with CTPCA) to lower costs and / or improve care and access for employees

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## Perspectives: Patient / Consumer



01 Substantial 'cost sharing' in the form of co-insurance, deductibles and large co-payments driving decisions about access, utilization and provider selection

02 Desire for convenient, efficient care and plenty of competition to serve them (retail based clinics, urgent care centers)

03 Expectations for service, use of technology, 'on demand' interactions, social communications

04 Involvement of Payer / Employer in chronic care

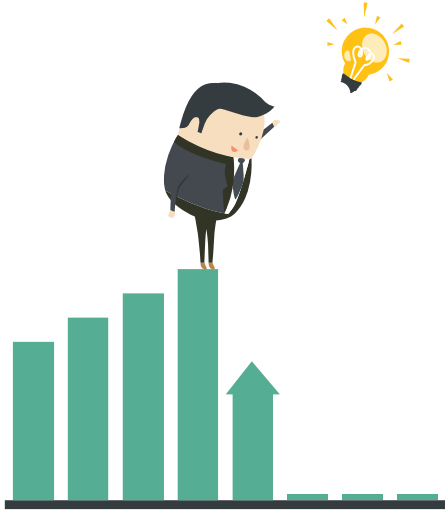
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## Perspectives: Yours!



### Challenges to Independence

- ✓ Solo and small practices may not have the resources or technology to restructure operations to respond to new payment system incentives, medical home demands, expectations
- ✓ More practices merging and / or joining physician associations and organizations (ACOs, IPAs, PHOs, etc.)
- ✓ Increase in physician employment at hospitals, fewer small private practices
- ✓ More complexity with insurers, many plan designs
- ✓ More complexity with regulations and government programs

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## Some Housekeeping Matters...



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## Blended vs. Line Item

Line Item Example				Blended Example			
CPT Code	Par Amount	Rate (%)	Rate (\$)	CPT Code	Par Amount	Rate (%)	Rate (\$)
99211	\$ 20.99	136%	\$ 28.55	99211	\$ 20.99	200%	\$ 41.98
99212	\$ 44.79	136%	\$ 60.91	99212	\$ 44.79	200%	\$ 89.58
99213	\$ 74.07	136%	\$ 100.74	99213	\$ 74.07	80%	\$ 59.26
99214	\$ 108.63	136%	\$ 147.74	99214	\$ 108.63	100%	\$ 108.63
99215	\$ 145.11	136%	\$ 197.35	99215	\$ 145.11	100%	\$ 145.11
		<b>136%</b>	<b>\$ 535.28</b>			<b>136%</b>	<b>\$ 444.56</b>

Line Item	\$ 535.28
Blended	\$ 444.56
Variance (\$)	\$ 90.73
Variance (%)	20.41%

Please see disclaimer on slide 2 of this presentation as related to prices listed and/or use of CPT codes above

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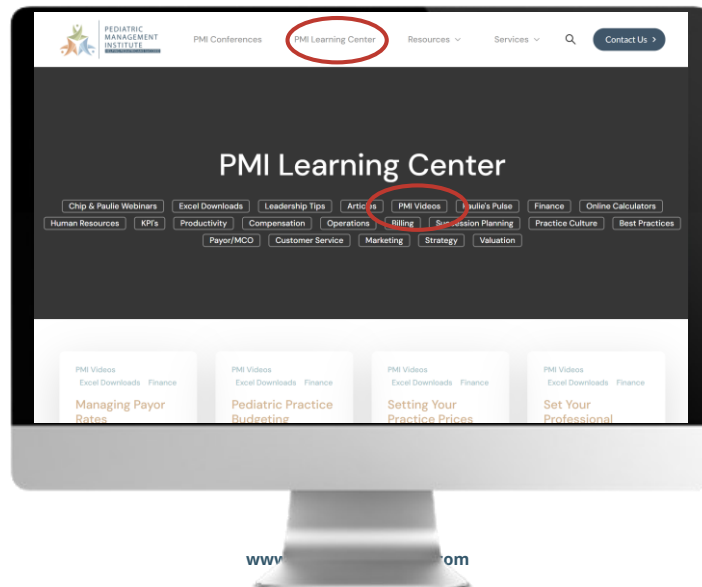
## Keep Eye On Vaccine Payments

- Most plans will not negotiate vaccine payments
- Rely on Average Wholesale Price (AWP)
- Leverage Buying Groups To Reduce Costs

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## Online Learning



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## Assessing Cost of Doing Business

### Administrative costs

- Ease / difficulty of business processes, policies etc.

### Claims Management Costs

- Number of fee schedules / differentiation of fees (doc vs. midlevel)
- Number of plans / products to manage
- Denial management

### Hassle factors

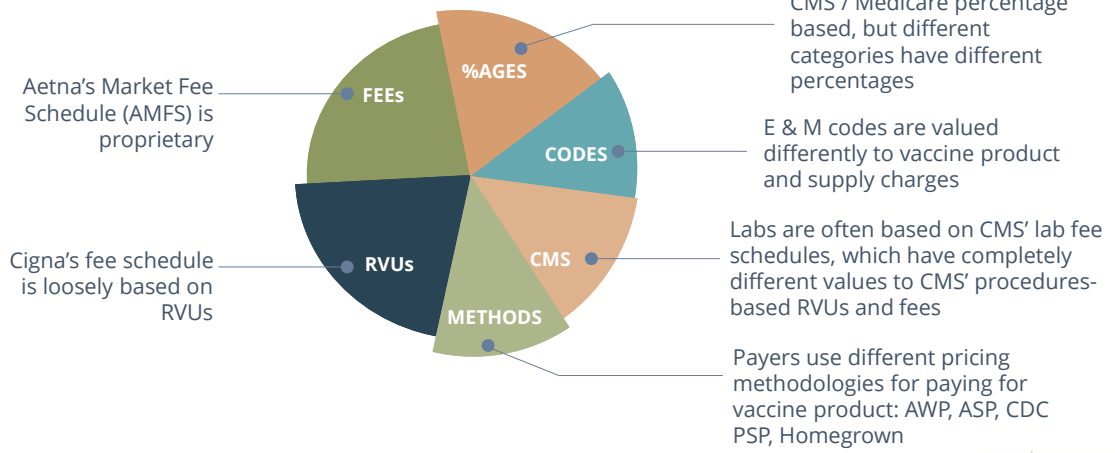
- Unique coding issues
- Lack of customer service / support
- DAR, processing errors

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# Payer Payment Methodologies

Many Payers do not base their fees on CMS / Medicare



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# Most 'Popular' P4P Models

## Shared Savings/Gain Sharing

- Contracts are designed based on sharing SAVINGS;
- A portion of the savings (10% to 50%) is returned to the practice or organization

Providers implement certain cost-saving measures and / or performance metrics

- On FFS: typically increases between 1%-6% of FFS payments
- In addition to FFS: quarterly bonuses & PMPM
- Expect to see move to NP4PP (no-pay-for-poor-performance) as quality of care improves within networks

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## Benefit Design Shaping the Market



### Employer Savings Demands + Physician 'Profiling' Driving Access

01

Self-funded Employers want to hold the line on costs

02

Payers rolling out benefit designs to meet challenges, including narrow networks and tiering

03

Penalizes patients for selecting 'high cost' providers by imposing higher out-of-pocket costs for co-pays and co-insurance

Patient cost share and physician payment rates are set according to tiering; higher copays for receiving care from providers with lower 'grades'; less pay for those providers who don't make the grade (coming soon)



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## Commercial Payer VBP Models



### Narrow Networks & HIX

01

'Tiered' networks at the heart of the Healthcare Insurance Exchange Plans (HIX) and Employer Self-Funded Plans

02

Network Selection for Narrow Networks

- Less expensive practices
- High performing ones (e.g. PCMH tiers)

03

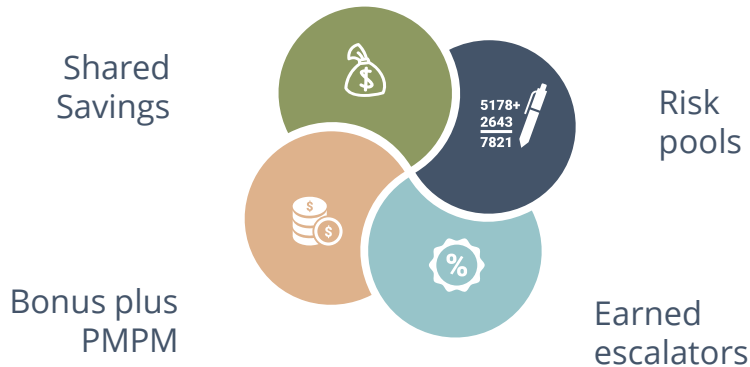
Determination of who makes the cut factors in rates, referral patterns and hospital relationships

- Potential for Payers to drop 'poor-performing' providers from their networks; idea is to pay only for high-quality, low-cost care
- Employer tiering e.g. hospitals that restrict employees access to non-employed providers



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## Types of VBP Contracts



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## Shared Savings Pool

### 3. SHARED SAVINGS POOL

Subject to the terms of the Participating Provider Agreements, the amounts received by DCHA (and/or an accountable care organization, physician network or similar organization through which DCHA directly or indirectly provides a panel of its CI Network providers) in connection with “Class 1 Provider Contracts” that include Value-Based Care Programs (such amounts received during a calendar year, the “Shared Savings Payments”) shall be distributed as follows, as amended from time to time by the DCHA Board:

- a. An amount equal to 50% of the Shared Savings Payments up to the PMPM Threshold (as defined below) and 25% of the Shared Savings Payments after the PMPM Threshold will be retained to support activities during the performance period to which the Shared Savings Payments relate and offset the costs in connection with developing and supporting the CI Network and the role of DCHA (and/or an accountable care organization, physician network or similar organization through which DCHA directly or indirectly provides a panel of its CI Network providers) in connection with the Value-Based Care Programs (the “Retention Amount”).
- b. The amount of Shared Savings Payments remaining after deduction of the Retention Amount will be used to fund a shared savings pool (the “Shared Savings Pool”) to be distributed to participating physician groups who meet the eligibility requirements described in



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## Bonus Plus PMPM

Section 4; provided, however, such distribution shall not take into account the volume or value of referrals or other business generated by the participating physician group and/or its physicians.

For purposes of this Distribution Policy, the term "PMPM Threshold" means the amount equal to the amount of shared savings retained by DCHA equal to \$3.00 PMPM.

50% → distributed, up to \$3 PMPM  
 25% → retained for costs  
 ?% → for shared savings pool (25%? - not spelled out)

## Earned Escalators

Table 1

Performance Measure	Measurement Period	Target Score	Fee Schedule Inflator	Fee Schedule Inflator Effective Date
Generic Prescriptions %	1-1-11 – 5-31-11	60% or higher	0.25%	1-1-2012
	6-1-11 – 5-31-12	65% or higher	0.25%	1-1-2013
	6-1-12 – 5-31-13	70% or higher	0.25%	1-1-2014
Tier 1 Prescriptions %	1-1-11 – 5-31-11	X% or higher	x.x%	1-1-2012
	6-1-11 – 5-31-12	X% or higher	x.x%	1-1-2013
	6-1-12 – 5-31-13	X% or higher	x.x%	1-1-2014
Non-Participating Lab Provider Referrals %	1-1-11 – 5-31-11	X% or lower	x.x%	1-1-2012
	6-1-11 – 5-31-12	X% or lower	x.x%	1-1-2013
	6-1-12 – 5-31-13	X% or lower	x.x%	1-1-2014
Non-Participating Free Standing Ambulatory Surgery Center Claims %	1-1-11 – 5-31-11	X% or lower	x.x%	1-1-2012
	6-1-11 – 5-31-12	X% or lower	x.x%	1-1-2013
	6-1-12 – 5-31-13	X% or lower	x.x%	1-1-2014
EMR Utilization	1-1-11 – 8-31-11	X% or higher	x.x%	1-1-2012
	9-1-11 – 8-31-12	X% or higher	x.x%	1-1-2013
	9-1-12 – 8-31-13	X% or higher	x.x%	1-1-2014
E-Prescription Utilization	1-1-11 – 8-31-11	X% or higher	x.x%	1-1-2012
	9-1-11 – 8-31-12	X% or higher	x.x%	1-1-2013
	9-1-12 – 8-31-13	X% or higher	x.x%	1-1-2014
Electronic Registry Utilization	1-1-11 – 8-31-11	X% or higher	x.x%	1-1-2012
	9-1-11 – 8-31-12	X% or higher	x.x%	1-1-2013
	9-1-12 – 8-31-13	X% or higher	x.x%	1-1-2014
National Committee for Quality Assurance (NCQA) Physician Practice Connections (PPC) Level 1-3	[Medical Group Defined based on NCQA Review Timeline]	Level X or higher	x.x%	1-1-2012
		Level X or higher	x.x%	1-1-2013
		Level X or higher	x.x%	1-1-2014

## Risk Pool

- b. Fund Risk Allocations. The allocation of the upside bonus percentages and associated Surplus resulting from the various funds as between Health Plan and Contracted Provider shall be as set out in Table 1.

**Table 1**

Fund	Bonus Limit	Contracted Provider Surplus	Health Plan Surplus
Operating Fund	33% of total primary care physician services payments	50%	50%

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## Risk Pool

- d. Summary of Calculation of the Potential Bonus Payment.

- (Net Operating Fund \* Table 1 Percent) = Net All Funds
- (PCP capitation payment + Contracted Provider claims) \* 33% = Bonus Limit
- Lesser of Net All Funds or Bonus Limit = Available Bonus Amount
- Available Bonus – Prior Payments = Potential Bonus Due

The Bonus Limit is based on the requirements found in 42 CFR §§ 422.208 and 417.479.

Prior Payments means the bonus payments made to Contracted Provider in prior months.

No Bonus will be due or payable for any Reporting Period in which Contracted Provider is in a Deficit.

- e. Aggregate Deficit in Operating Fund. If there is an aggregate Deficit attributed to Contracted Provider from the reconciliation for the Net Operating Funds or its Affiliate from reconciliation of other service funds for more than three consecutive Reporting Periods, Health Plan may (i) immediately discontinue the upside bonus arrangement hereunder upon notice to Contracted Provider, or (ii) terminate the Agreement upon 60 days notice to Contracted Provider. In no event will Contracted Provider be paid a bonus if it is in a Deficit under this Agreement or any Other Risk Agreement. If Contracted Provider or its Affiliate is in an Other Risk Agreement for which it is responsible for payment of the Deficit, then that Deficit will be payable under such arrangement by Contracted Provider or its Affiliate.



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## Impact On Net Income

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	Current	
Payor Revenue	\$	1,250,000
Allocated Expenses	\$	850,000
Allocated Overhead		68.00%
Margin For Provider Comp / Profit	\$	400,000

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## Impact On Net Income

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	Current		Expected	
Payor Revenue	\$	1,250,000	\$	1,125,000
Allocated Expenses	\$	850,000	\$	850,000
Allocated Overhead		68.00%		75.56%
Margin For Provider Comp / Profit	\$	400,000	\$	275,000

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## Impact On Net Income

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	Current	Expected	Variance	
Payor Revenue	\$ 1,250,000	\$ 1,125,000	\$ (125,000)	-10.00%
Allocated Expenses	\$ 850,000	\$ 850,000		
Allocated Overhead	68.00%	75.56%		
Margin For Provider Comp / Profit	\$ 400,000	\$ 275,000	\$ <b>(125,000)</b>	<b>-31.25%</b>

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## Impact On Net Income

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	Current	Expected	Variance	
Payor Revenue	\$ 1,250,000	\$ 1,125,000	\$ (125,000)	-10.00%
Allocated Expenses	\$ 850,000	\$ 850,000		
Allocated Overhead	68.00%	75.56%		
Margin For Provider Comp / Profit	\$ 400,000	\$ 275,000	\$ <b>(125,000)</b>	<b>-31.25%</b>

	Current	Expected	Variance	
Payor Revenue	\$ 1,250,000	\$ 1,375,000	\$ 125,000	10.00%
Allocated Expenses	\$ 850,000	\$ 850,000		
Allocated Overhead	68.00%	61.82%		
Margin For Provider Comp / Profit	\$ 400,000	\$ 525,000	\$ <b>125,000</b>	<b>31.25%</b>

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# Track Overall Performance (Quick & Dirty)

	Total Charges	Percent of Charges	Total Adjustments	Percent of Adjustments	Total Payments	Percent of Payments	Net A/R	Percent of A/R	Gross Collection Rate	Net Collection Rate
Payor 1	\$ 818,000	40.90%	\$ 350,000	43.75%	\$ 450,000	38.96%	\$ 18,000	40.00%	55.01%	96.15%
Payor 2	\$ 410,000	20.50%	\$ 170,000	21.25%	\$ 235,000	20.35%	\$ 5,000	11.11%	57.32%	97.92%
Payor 3	\$ 340,000	17.00%	\$ 130,000	16.25%	\$ 200,000	17.32%	\$ 10,000	22.22%	58.82%	95.24%
Payor 4	\$ 265,000	13.25%	\$ 90,000	11.25%	\$ 165,000	14.29%	\$ 10,000	22.22%	62.26%	94.29%
Payor 5	\$ 167,000	8.35%	\$ 60,000	7.50%	\$ 105,000	9.09%	\$ 2,000	4.44%	62.87%	98.13%
<b>Total</b>	<b>\$2,000,000</b>		<b>\$ 800,000</b>		<b>\$1,155,000</b>		<b>\$ 45,000</b>		<b>57.75%</b>	<b>96.25%</b>

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# CPT Tracking Grid (For Payment Posters)

	A	B	C	D	E	F	G	H	I	J	K	L
1	MCO Payment Comparisons											
2												
3		Payor 1	Payor 2	Payor 3	Payor 4	Payor 5	Payor 6	Payor 7	Payor 8	Payor 9	Payor 10	
4	<b>Labs</b>											
5	36416-Capillary blood draw											
6	81002-Urinalysis nonauto w/o scope											
7	82270-Occult blood feces											
8	82465-Assay bld/serum cholesterol											
9	83655-Assay of lead											
10	85018-Hemoglobin											
11	87420-Resp syncytial ag ia											
12	87430-Strep a ag ia											
13	87804-Influenza assay w/optic											
14	87880-Strep a assay w/optic											
15	99000-Specimen handling office-lab											
16	<b>Vaccine Admins</b>											
17	90460-Im admin 1st/only component											
18	90461-Im admin each addl component											
19	90471-Immunization admin											
20	90472-Immunization admin each add											
21	90473-Immune admin oral/nasal											
22	90474-Immune admin oral/nasal addl											
23	<b>Behavioral / Health Assessments</b>											
24	96110-Developmental screen w/score											
25	96111-Developmental test extend											
26	96127-Brief emotional/behav asmt											
27	96150-Assess hlth/behav init											
28	96151-Assess hlth/behav subseq											
29	96160-PT-focused hlth risk asmt											
30	96161-Caregiver health risk asmt											
31	<b>Office Visits</b>											
32	99203-Office/outpatient visit new											
33	99204-Office/outpatient visit new											
34	99213-Office/outpatient visit est											
35	99214-Office/outpatient visit est											





# Payor Proposal Review

Current Rates	\$ 325,071
Proposed Rates	\$ 326,999
Variance	\$ 1,928

CPT Code	CPT Description	Count	Current Rates		Proposed Rates		Variance
			Rate	Revenue	Rate	Revenue	
90460	Im admin 1st/only component	800	\$ 25.00	\$ 20,000	\$ 26.00	\$ 20,800	\$ 800
90461	Im admin each addl component	746	\$ 11.00	\$ 8,206	\$ 10.00	\$ 7,460	\$ (746)
90471	Immunization admin	24	\$ 17.00	\$ 408	\$ 17.00	\$ 408	\$ -
90472	Immunization admin each add	2	\$ 17.00	\$ 34	\$ 17.00	\$ 34	\$ -
99000	Specimen handling office-lab	90	\$ 11.00	\$ 990	\$ 5.00	\$ 450	\$ (540)
99202	Office o/p new sf 15-29 min	0	\$ 94.00	\$ -	\$ 92.00	\$ -	\$ -
99203	Office o/p new low 30-44 min	2	\$ 145.00	\$ 290	\$ 145.00	\$ 290	\$ -
99204	Office o/p new mod 45-59 min	2	\$ 172.00	\$ 344	\$ 187.00	\$ 374	\$ 30
99205	Office o/p new hi 60-74 min	0	\$ 285.00	\$ -	\$ 257.00	\$ -	\$ -
99211	Off/op est may x req phy/ghp	5	\$ 28.00	\$ 140	\$ 30.00	\$ 150	\$ 10
99212	Office o/p est sf 10-19 min	11	\$ 55.00	\$ 605	\$ 55.00	\$ 605	\$ -
99213	Office o/p est low 20-29 min	604	\$ 92.00	\$ 55,568	\$ 93.75	\$ 56,625	\$ 1,057
99214	Office o/p est mod 30-39 min	326	\$ 134.00	\$ 43,684	\$ 132.50	\$ 43,195	\$ (489)
99215	Office o/p est hi 40-54 min	98	\$ 180.00	\$ 17,640	\$ 207.00	\$ 20,286	\$ 2,646
99381	Init pm e/m new pat infant	21	\$ 138.00	\$ 2,898	\$ 130.00	\$ 2,730	\$ (168)
99382	Init pm e/m new pat 1-4 yrs	4	\$ 124.00	\$ 496	\$ 120.00	\$ 480	\$ (16)
99383	Prev visit new age 5-11	2	\$ 151.00	\$ 302	\$ 148.00	\$ 296	\$ (6)
99384	Prev visit new age 12-17	5	\$ 170.00	\$ 850	\$ 174.00	\$ 870	\$ 20
99391	Per pm reeval est pat infant	154	\$ 125.00	\$ 19,250	\$ 125.00	\$ 19,250	\$ -
99392	Prev visit est age 1-4	203	\$ 133.00	\$ 26,999	\$ 133.00	\$ 26,999	\$ -
99393	Prev visit est age 5-11	180	\$ 132.00	\$ 23,760	\$ 132.00	\$ 23,760	\$ -
99394	Prev visit est age 12-17	148	\$ 145.00	\$ 21,460	\$ 145.00	\$ 21,460	\$ -
99395	Prev visit est age 18-39	27	\$ 149.00	\$ 4,023	\$ 149.00	\$ 4,023	\$ -



## Sample MCO Contract Abstraction Sheet

	BBMCO	MCO1	MCO2	
<b>Phase I- Inquiry</b>				
Contract Effective Date(s):	January 1, 2020			
Renewal Date	January 1, 2021			
Days Notice To Cancel	90 Days			
Network Name(s):	Little Apples, Orange Grove			
Product Type(s):	PPO, HMO, EPO			
Products/Networks/Plans Not Contracted for:	Medicare Advantage			
Network Contracted Through	Direct / IPA / CIN, etc.			
Largest Employer In Area	Wal Mart			
# 2 Employer In Area	Coca Cola Bottler			
# 3 Employer In Area	ABC Community Hospital			
Current Number of Patients Covered (GWP Actives)	2500			
Factor of Medicare RBRVS	125%			
Factor of Medicare RBRVS Year				
Factor of Medicare GPCI Applied				
Medicare RBRVS Method	(Blended or Line by line)			
Medicare RBRVS Year	Current Year (2020)			
Nurse Practitioner Rates	No Differential			
Nurse Practitioner Rates Source	<a href="http://www.BBMCO.com/np_rate_rules">www.BBMCO.com/np_rate_rules</a>			
Physician Assistant Rates	No Differential			
Physician Assistant Rates Source	<a href="http://www.BBMCO.com/pa_rate_rules">www.BBMCO.com/pa_rate_rules</a>			
Medicare Fee Schedule Information	<a href="https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html">https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html</a>			
Escalator(s) Available	.09% Increase each year to initial contracted rates.			
Immunizations Rate	100% of AWP			
Immunization Pricing Source	Not specified			
Immunization Rate Update	Quarterly			
Laboratory Pricing Program				
<b>Phase II- Contract Details</b>				
Lessor of Billed Charges or Medicare RBRVS	Unless prohibited by the network agreement, BBMCO has the right to pay the lesser of the contract rate or billed charges			
Site of Service Differentials	N/A			
Non-Immunization with CMS ASP	100% ASP + 6% (Current Medicare)			
Non-Immunization with no CMS ASP	140% of RBRVS for non-immunizations with no CMS ASP, 80% of billed charges for codes not included in the current CMS RBRVS fee schedule			
ASP Information	<a href="http://www.BBMCO.com/asp_info">www.BBMCO.com/asp_info</a>			
Vaccine Carve-Out Rate Notes	N/A			
Lab Carve-Out Rate Note	N/A			
DME Carve-Out Rate Note	100% of current year Medicare RBRVS			
All Other Carve-Out Notes	N/A			
Default Rate	80% of billed charges (all services with no payment rate assigned)			
Locum Tenens Rates	No Differential			
Locum Tenens Rates Source	<a href="http://www.BBMCO.com/locum_rate_rules">www.BBMCO.com/locum_rate_rules</a>			
Provider Profiling				
Consumer Lookup Site	<a href="http://www.BBMCO.com/provider_ratings">www.BBMCO.com/provider_ratings</a>			
Current MCO Rating	3 of 5 stars with "Above Average Costs"			
Rating adjustment frequency	Annually- March			
Rating notification	Direct to provider			
Rating appeal timeline	30 days			
Consumer review rating	5 of 5 stars			
Incident-To Billing Guidelines	<a href="http://www.BBMCO.com/incident_to_rules">www.BBMCO.com/incident_to_rules</a>			
Operational Summary				
Coding Updates:	BBMCO follows coding standards as established by CMS			
Timely Filing Requirement:	90 days from the date of service			
Timely Payment Requirement/Penalty:	Clean claims shall be paid, denied, or settled within thirty (30) calendar days after receipt if submitted electronically, within forty-five (45) days after receipt if submitted by paper. Thirty (30) days prior written notice by either party, or upon the effective date of a fully executed Provider Participation Agreement			
Termination Without Cause:				

# Understanding the New Contracts

Understand what is being offered and how the contracts work

### 1 Risks

Is it all upside or are there risks associated? (e.g. withheld payments)

### Requirements 3

Do you have the ability to meet the requirements of these programs (through IT capability, provider buy-in, etc.)

### 2 Bonus?

Are you able to effectively calculate your potential 'bonus'?

### Improvements 4

Can you effectively measure where you stand today and if targets for improvement are likely to be met within the measurement period?



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# Beware Value-Based Profiling & Tiering

## Physician 'Profiling'



01

Big data allows more visibility into payments and utilization

02

Penalizes patients for selecting 'high cost' physicians and hospitals by imposing higher out-of-pocket costs for co-pays and co-insurance

03

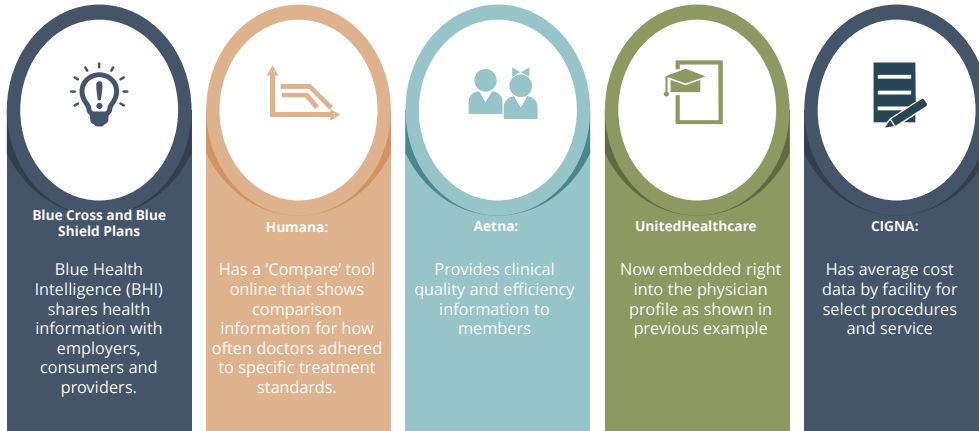
Performance measurement programs based on claims data primarily  
- Patient cost share and physician payment rates are set according to tiering; higher copays for receiving care from providers with lower 'grades';  
- Less pay for those providers who don't make the grade may be coming next

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## Examples of Profiles for Consumers

Several insurers offer their members information on costs, clinical quality and physician efficiency:



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## How To Maintain A High 'Score'

### 1. Check Your Profile

Check your profile in the Payers directories to see how you rate

### 2. Score

If you have a score that is less than perfect, contact the insurance company and find out why

### 3. Review

Ask them to send you the underlying data supporting your score, review it, and contest the data if they are incorrect, by showing them your patient records. We have seen pediatricians get 'dinged' for lack of a mammography when clearly that is not a patient that should have been attributed to that physicians panel

### 4. Contest

If you receive a packet in the mail, which you should annually, open it and review it. Contest any data that is incorrect. Payers usually give you 30 days to review and contest before they lock in the score . . .



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# Example: Physician Profiling

United Healthcare

Messages Search My Account

Home Find Care & Costs Claims & Accounts Coverage & Benefits Pharmacies & Prescriptions

Find care / Search results

Choose Eloise's primary care provider

Search by name, procedure, or condition  
Primary Care

Location  
17803 Country Cove, Cypress...

Results for primary care

Provider results

**Cost**

- Above Average (\$\$\$):** This provider's service cost is more than those of similar providers in your ZIP code.
- Average (\$\$\$):** This provider's service cost is like those of similar providers in your ZIP code.
- Below Average (\$\$\$):** This provider's service cost is less than those of similar providers in your ZIP code.

To understand costs for specific services for this provider, check out the Cost section of this provider detail view.

**Elizabeth S Fowler, M.D.**  
Pediatrician  
4.1 (23)  
4.7 mi • 14502 Cypress Mill Place Blvd Ste ...  
Choose PCP (281) 374-9700

**Trung D Dinh, MD**  
Family Practice  
In-network  
3.7 (20)  
2.7 mi • 15201 Mason Rd Ste 1200  
Choose PCP (281) 373-0162

**Wilson Rodrigo Moscoso-do...**  
Family Practice  
In-network  
3.5 (8)  
3.5 mi • 27700 Highway 290 Ste 100  
Choose PCP (346) 231-...

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# Example: Physician Profiling

United Healthcare

United Healthcare

Home Find Care & Costs Claims & Accounts

Find care / Search results / Provider details

Choose PCP Premium Care Physician

Premium Care Physician

This physician meets the UnitedHealth Premium® quality care criteria which includes safe, timely, effective and efficient care.

Learn more about the Premium Program

About

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Pediatrician

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### Select a care type

Office visits ▾

A brief assessment of a patient's emotional and behavioral health	Estimated Average Cost:\$6	\$\$\$ Average	Get full cost estimate
A live chickenpox (varicella virus) vaccine solution injected to protect against infection	Estimated Average Cost:\$194	\$\$\$ Average	Get full cost estimate
A screening test of the inner ear, limited eval, 3-6 frequencies	Estimated Average Cost:\$29	\$\$\$ Average	Get full cost estimate
A short office visit with a physician or other provider for an established patient	Estimated Average Cost:\$26	\$\$\$ Average	Get full cost estimate
A solution of Hepatitis A prepared for a vaccination, given in a series of two shots	Estimated Average Cost:\$45	\$\$\$ Above average	Get full cost estimate
A solution of flu vaccine to be given as a nasal spray	Estimated Average Cost:\$29	\$\$\$ Average	Get full cost estimate
A vaccination given by mouth, nose or injection (shot), first vaccine	Estimated Average Cost:\$24	\$\$\$ Average	Get full cost estimate



← Back

**A short office visit with a physician or other health care provider - Primary Care - billed under medical benefit - 99211 (CPT)**

For Paul >

This is a cost estimate using your medical benefits.  
Review the cost estimate using your behavioral health benefits. ⓘ


You pay: **\$25**  
Average cost ▾

In-network Out-of-network

### Estimate details

How are these providers and facilities chosen? [Learn More](#) >

**A short office visit with a physician or other health care provider** >



Pediatrics  
★★★★☆ 23 Reviews  
Cypress, TX • 3 Miles  
Average cost ⓘ

You Pay (In-network)  
**\$25**

[Change provider](#)

### Cost summary

Total cost before coverage	\$27
<b>Average cost</b> ⓘ	
Your health care plan pays	-\$2
<b>You pay</b>	<b>\$25</b>

This is a cost estimate using your medical benefits.  
Review the cost estimate using your behavioral health benefits. ⓘ

### Paul's plan

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## What To Do To Prepare

Assess the capabilities of your current information systems abilities to track and report the information that will be required to meet new contract terms



Can you understand the needs of your patient population?



Are you ready to e-prescribe?



Can you extract data from your patient records to demonstrate performance? (very difficult to manage from paper charts)



Will you need to invest to fill gaps? If you do not yet have an EMR, it will be impossible to work in a data-driven environment . . .

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## What To Do To Prepare

Assess the capabilities of your staff and resources to deliver care under new models



01

Do you have a method for creating and implementing protocols?

02

Can care be effectively coordinated by your team?

03

What communication processes are currently in place with your patients? Do you have follow up procedures in place?

04

Will your current resources be able to adjust their skills to meet new opportunities?

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## What To Do To Prepare



Assess whether the quality programs being offered by your largest plans are likely to create revenue opportunities commensurate with the effort required

- Evaluate which offerings can benefit you today
- Start preparations for mandatory changes coming tomorrow



New contracting initiatives will require physician behavior modification

- Determine how willing your physicians are to embrace change and begin planning for it now

## Best Bets

### Start developing

Start developing clinical quality, patient education and preventive / counseling programs now

### Join a larger group or organization

Join an IPA, ACO, Super-group or other organized entity that may offer enhanced rates in return for compliance in producing quality care

### Become a Medical Home

Recognition will be key to taking advantage of incentive bonuses / preserving payment rates









## Contract Questions to Ask

1. Are third party administrator, network brokers or repricers defined? Is there a "hold harmless" clause as a "Payer" in this contract?
2. Does this contract subject the "Provider" to a 'rental network PPO?
3. Is this contract subject to an "All Products" provision?
4. What is the methodology used for "General Offsets and Adjustments"?
5. Is there a "Comparable Provider Rate" or "Most-favored nations" provision?
6. What year of Medicare fee schedule is being used?
7. What is the precise methodology used in payment?
8. Is "rate averaging or weighting" used in your formula of payment?
9. Are Medicare's Coding Edits used or does the plan have it's own coding edits, or a coding companion guide?
10. How do I access information and how often are the edits revised?
11. What are the steps to be taken for litigation?
12. Will the Provider and Non-Physician Providers be allowed to give advice or counsel to the enrollee concerning his or her current
13. Is there a "hold harmless" clause?
14. Does the plan carry re-insurance?
15. Are your stop-loss provisions per enrollee based on total dollars or on a case by case basis?
16. What is the definition of catastrophic illness and the protocol for reporting?
17. Will "consideration privileges" be granted in the event the credentialing process is longer than 90 days?
18. How long must we see enrollee's after termination of this contract?
19. Is there a cap on damages in the event liability?
20. Does this contract differ in statute of limitations from the state in which the "Provider" is practicing?
21. Who is the Medical Director and the Director on the Panel of my specialty? What is their location, phone number and email address?

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## Traps

 <p>Vaccine Carve Outs</p>	 <p>Vaccine Rates</p>	 <p>Blended vs. Line Item</p>	 <p>Evergreen Contracts</p>
 <p>Favored Nations Clauses</p>	 <p>Hide Issues in Policies &amp; Procedures</p>	 <p>Using Various Medicare Rates (Varies by Year)</p>	 <p>They Will Lie!</p>

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## Responding to the enemy...



**When you hear this...**  
 "I'm not authorized to make that decision"  
**Say this...**  
 "Who should I be talking to?"

**When you hear this...**  
 "I'll get back to you on that"  
**Say this...**  
 "When can I expect a response?"

**When you hear this...**  
 "We can't afford that"  
**Say this...**  
 "You Earned X amount last year"

**When you hear this...**  
 "We can't send you rates for thousands of codes"  
**Say this...**  
 "Send me the rates for my top 25 codes"

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## Are CIN's Right For You?

Clinically  
Integrated  
Networks

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## Status Quo

- Lack of influence for proper payments for quality care
- Lack of infrastructure to deliver cost savings to payors
- Lack of capital to consider risk-based contracts
- Lack of expertise to manage emerging forms of contracts
- Reliance n “Messenger Model” contracting

## Future With CIN

- Jointly negotiated contracts
- Setting the standards for “Quality Care”
- IT / Data sharing to identify opportunities to improve the quality & access to care for children
- Shared resources / investments to deliver value & cost savings to payors

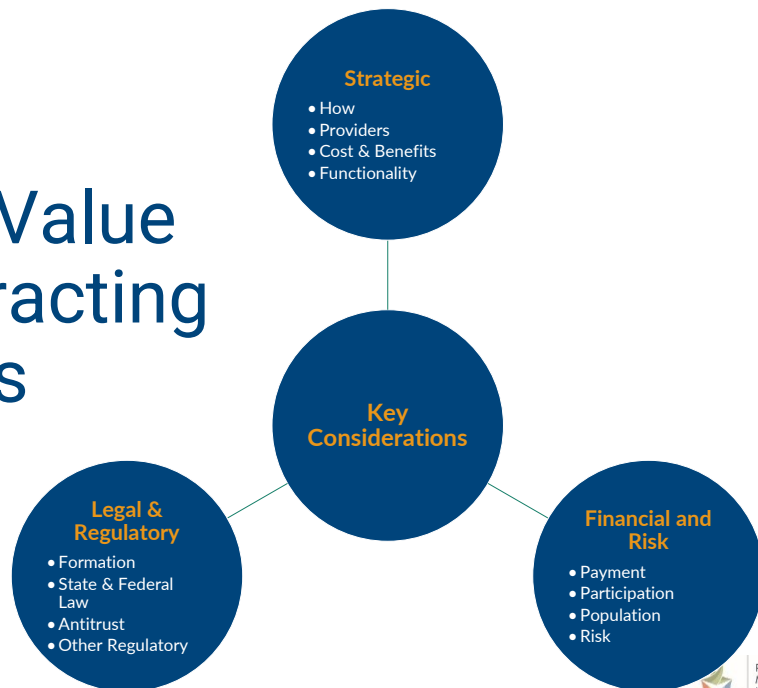
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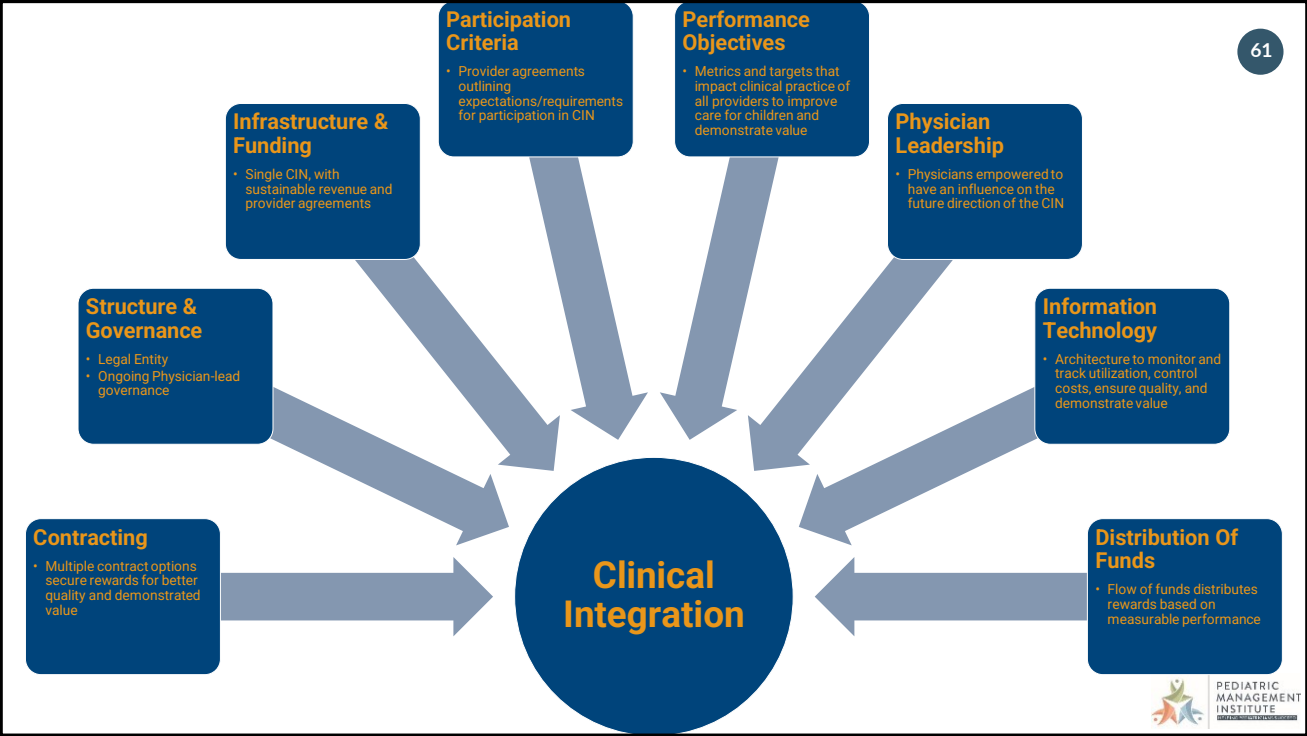
# Innovative Value Based Contracting Models

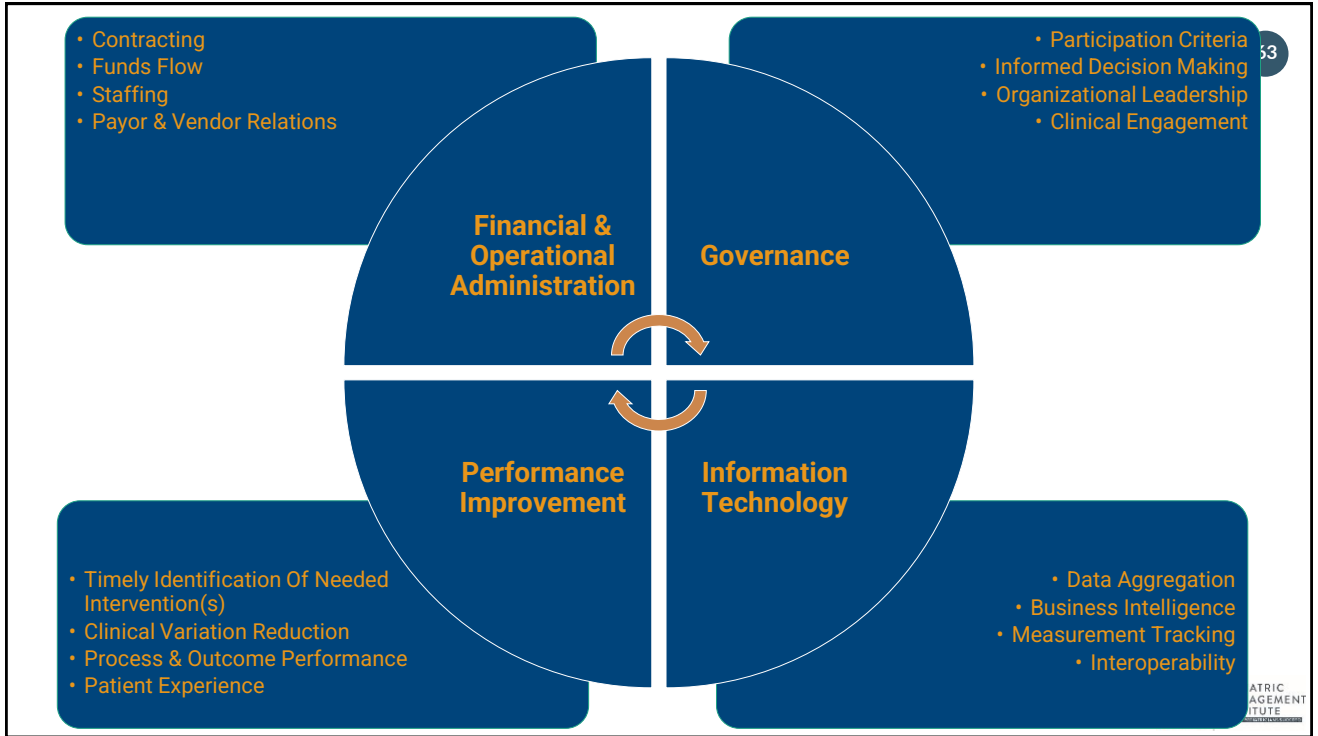


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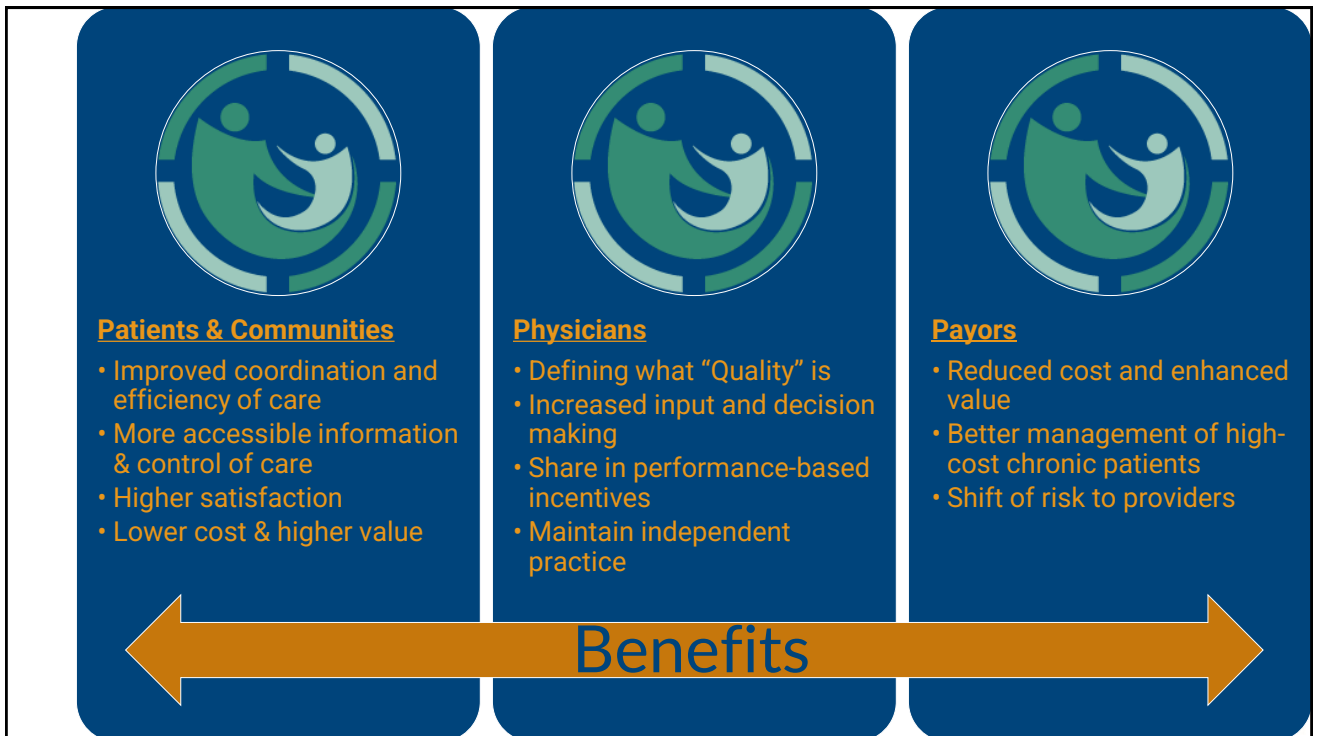


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## Topics Covered & Dates

<p><b>Set Your Practice Fees</b></p> <p>Wednesday, August 28, 2024</p>	<p><b>Practice Budgeting Tool</b></p> <p>Thursday, September 5, 2024</p>	<p><b>Managing Payor Rates</b></p> <p>Wednesday, September 25, 2024</p>
<p><b>Provider Margin Reviews</b></p> <p>Wednesday October 9, 2024</p>	<p><b>Employed Provider Bonus Models</b></p> <p>Wednesday, October 16, 2024</p>	<p><b>Split The Pot</b></p> <p>Wednesday, October 23, 2024</p>



# THANK YOU

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