Practice Leadership Conference

Practice, Politics & Policy
Paying for Psychology’s Changing Roles in Health Care

Practice, Politics & Policy
Managed Care History

- Late 80s- early 90s - rapid consolidation of plans
- Look alike products developed
  - HMOS were more highly regulated
  - PPO regulation less strict
  - PPOs previously passive
  - Added additional managed care components
  - States started to approve EPOs
PHOs and Integrated Delivery Systems

• Hospitals and providers wanted to get more control, and tried to organize so they could keep the profits themselves

• Largely unsuccessful- providers thought they could just do the same thing and keep the money, but lost significant $$$
Payment Methodologies

• Private Pay
• Insured
  — Fee for Service
  — Fee Schedule
  — Percentage of Charges
• Managed Care
  — DRG
  — Bundled Payment
MOVING PARTS IN BUNDLE
PAYMENT NEGOTIATION

• Define the episode
• Define the price
• Define the payment
• Any patient incentives
EPISODE DEFINITION

— Scope of services
  • Service or clinical condition
    — Major diagnosis
    — Major medical event
    — Chronic condition over period (month?)

— Initiation
  • by acute hospital claim, other facility encounter?,
  • community entrant?

— Duration
  • Include testing pre-acute care episode?
  • Post acute
    — fixed (with prorating)
    — or variable length?
  • Interval between episodes
  • Challenges for chronic episodes

— Grouper
DEFINE THE PRICE

— Projected price based on prior experience
  • What period?
  • Same provider group?
  • Same patient group?
  • Same co-morbidities?
  • data on “all fours” with services in candidate bundle?
— Any case mix adjustment?
— Will patient severity be deemed constant?
  • Or adjusted when coding improves?
— Does the price reflect optimal treatment path?
  • “evidence informed rate?” (Prometheus)
  • Or simply past practice?
— Adjustment during or at the conclusion of the contract term
DEFINE PAYMENT

- What patients are subject to it?
- Retrospective?
- Prospective?
- Discounts to FFS before episode reconciled?
- Adjustments for comorbidities?
- Adjusted or predicated on attaining quality benchmarks?
- Any inflation factor?
- Any “step down” in price over term of contract?
- Any reopener if care path or technology changes?
ESSENTIAL CAPABILITIES FOR SUCCESS UNDER FUTURE REIMBURSEMENT MODELS

• More specifically, you need to be:
  — A provider that can manage additional cost reduction
  — A provider that is financially sound with the ability to cover at-risk amounts and make the required investments in infrastructure
  — A provider with robust information technology and monitoring capabilities
  — A provider with access to a stable primary care patient base
  — A provider with standardized clinical processes and protocols
  — A provider with strong governance, oversight, and change management structures
Regulatory Risks

• Corporate Practice of Medicine
• Fee Splitting
• Fraud and Abuse
• Self-Referral
  — Federal
  — State
• Antitrust
  — Sharing of Financial Information
  — Integration
Integration

Section 1 of the Sherman Act declares illegal “every contract, combination ... or conspiracy in restraint of trade or commerce…”

15 U.S.C. §1
Integration

Three Circumstances in which unrelated competitors who are health care providers are permitted to jointly negotiate with managed care organizations:

1) In the presence of organizational integration (e.g., through merger or transfer of control)

2) In the presence of financial integration (e.g., risk sharing and/or pooling of financial assets); and

3) In the presence of sufficient clinical integration
Clinical Integration

• Joint negotiation of price is a necessary restraint required by the proposed joint pricing; and

• That the proposed clinical integration permits quality clinical benefits not otherwise possible in the absence of joint pricing
Indicia of Clinical Integration

- Development of measurable goals to monitor utilization;
- Use of procedures to actively educate, review and assist physicians in meeting the goals of quality and appropriate utilization;
- Removal and/or discipline of physicians who cannot or will not meet the goals established;
- Implementation of specific case and disease management programs;
- Implementation of credentialing procedures;
- Development of an integrated computer system to disseminate practice standards and communications and allow physicians caring for the same patients to communicate and share clinical information more easily;
Indicia of Clinical Integration

- A non-exclusive network (e.g., payors be allowed to contract outside of the “program” with providers independently);
- Adoption of practice protocols, standards, and performance monitoring which are only feasible with joint negotiation in order to ensure participation of sufficient numbers of physicians;
- Facilitation of cooperative interaction and collaboration between providers to ensure that the right care is provided at the right time; and
- Significant investment of capital (both human (e.g. time) and monetary) by the physicians in the infrastructure necessary for implementation of the program.
Questions
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