

Brent Davis, VP, Payor Strategy, INTEGRIS

Payor Contracting Language Pitfalls



Brent Davis has more than 25 years' experience in managed care from both the provider and payor perspective with extensive knowledge of the Texas managed care and healthcare market.

Mr. Davis has held regional and national health system leadership positions at Presbyterian Health, Integris Health, Community Health Systems, and HealthSouth, in addition national roles with Team Health representing hospital-based physicians, and with managed care organizations Cigna Healthcare and Foundation Health. Mr. Davis has worked in 38 states across the country. His philosophy is to work strategically to ensure managed care contracting strategies align with the organizational strategic planning process and operational/clinical execution.

Mr. Davis seeks to work collaboratively with managed care organizations and self-funded employers to create win-win relationships. Brent graduated with a Master's and Undergraduate degrees from the University of Oklahoma and is a member of the Healthcare Financial Management Association (HFMA).



PAYOR STRATEGY

**T-Bones Annual Conference
September 28, 2023**

Brent Davis

AD Consulting

Representing – OrthoLoneStar



BRENT DAVIS – BIO

- More than 25 years' experience in managed care from both the provider and payor perspective with extensive knowledge of the Texas managed care and healthcare market; has also worked in 38 states across the United States.
- Held held regional and national health system leadership positions at large regional not-for-profit and large national for-profit integrated health systems, national roles with physician organizations and outpatient providers.
- Philosophy is to work strategically to ensure managed care contracting strategies align with the organizational strategic planning process and operational/clinical execution.
- Graduate with a Master's and Undergraduate degrees from the University of Oklahoma.
- Has a consulting organization with his wife Stacy Davis, a University of Oklahoma graduate with 20+ years of managed care experience. AD Consulting (a_d_consulting@icloud.com).

BRENT'S "TRUTHISMS"

- Two things in human history that have NEVER (almost) happened
- Nobody has EVER washed a rental car.
- A managed care plan has NEVER called a provider and said, "we want to pay you more tomorrow than we're paying you today."
- The "almost" story

STRUCTURAL FORCES COMPRESSING PROVIDER MARGINS

At current course and speed, Providers are quickly approaching financial unsustainability. Rapidly growing operating expenses and threats to revenue growth are putting tremendous pressure on margins.

Upward Cost Pressures:

- Uncontrolled Labor Spending Growth
- Malpractice Costs
- Increasing Reliance on IT Enablement
- Growth in Purchased Services

Providers already face threats to both volumes and prices, which will only intensify as a result of ongoing changes to payment policies, patient demographics, insurance benefits, and the competitive landscape. Combined, these trends reveal a long-term, revenue-driven margin challenge.

Downward Pricing Pressures:

- Direct Reimbursement Pressure
- Federalism & State Based Coverage Reform
- Dilution of Commercial Coverage
- Shifting Demographics & Payor Mix Evolution

MANAGED CARE PRODUCTS

- **HMO - Health Maintenance Organization**
 - Most restrictive, least choice for member
 - No benefits for out of network non-emergent care
 - Intensive Case Management
 - Lowest cost to employer/employee
 - 2% - Texas HMO penetration rate
- **POS (Point of Service)**
 - In-network benefits – are similar to HMO
 - Out of network benefits – deductible & co-insurance apply
 - Intensive Case Management
 - Mid-cost to employer/employee
 - 30% - Texas POS penetration rate

MANAGED CARE PRODUCTS

- PPO – Preferred Provider Organization
 - More flexibility
 - No referrals
 - Limited preauthorization requirements
 - Highest cost to employer/employee
 - Out of network benefits
 - 68% - Texas penetration rate; still a PPO state/market
- In the last 10 years, consumer preferences have shifted demand from HMO to POS & PPO products;
 - Seeing a more recent shift back to HMO or CDHP (consumer driven health plan)
- Insurance premiums have continued to increase at double digit rate significantly above inflation rates causing cost shift to consumers via high deductibles, higher co-pays/co-insurance rates, and premiums;
- Increased costs shifting membership to narrow networks or more restrictive benefits.

MANAGED CARE FUNDING TYPE(S)

- **Fully Insured & Affordable Care Act (ACA) Marketplace Plans**
 - Regulated by Texas Department of Insurance
 - Employer pays premium, insurance company at risk
 - Approximately 41% of Managed Care Membership in Texas is fully insured as of 2022
- **Self-Insured Employee Retirement Income Security Act (ERISA)**
 - Employer pays administrative fee to insurer to access network & process claims
 - Employer at risk
 - 41% of Managed Care Membership in Texas is fully insured as of 2022
 - However, with many of the national carriers (i.e., CVS/Aetna, Cigna, & UHC), often the self-insured ratio is between 60% - 90% self-funded vs. fully insured.

NEGOTIATING CONTRACTS

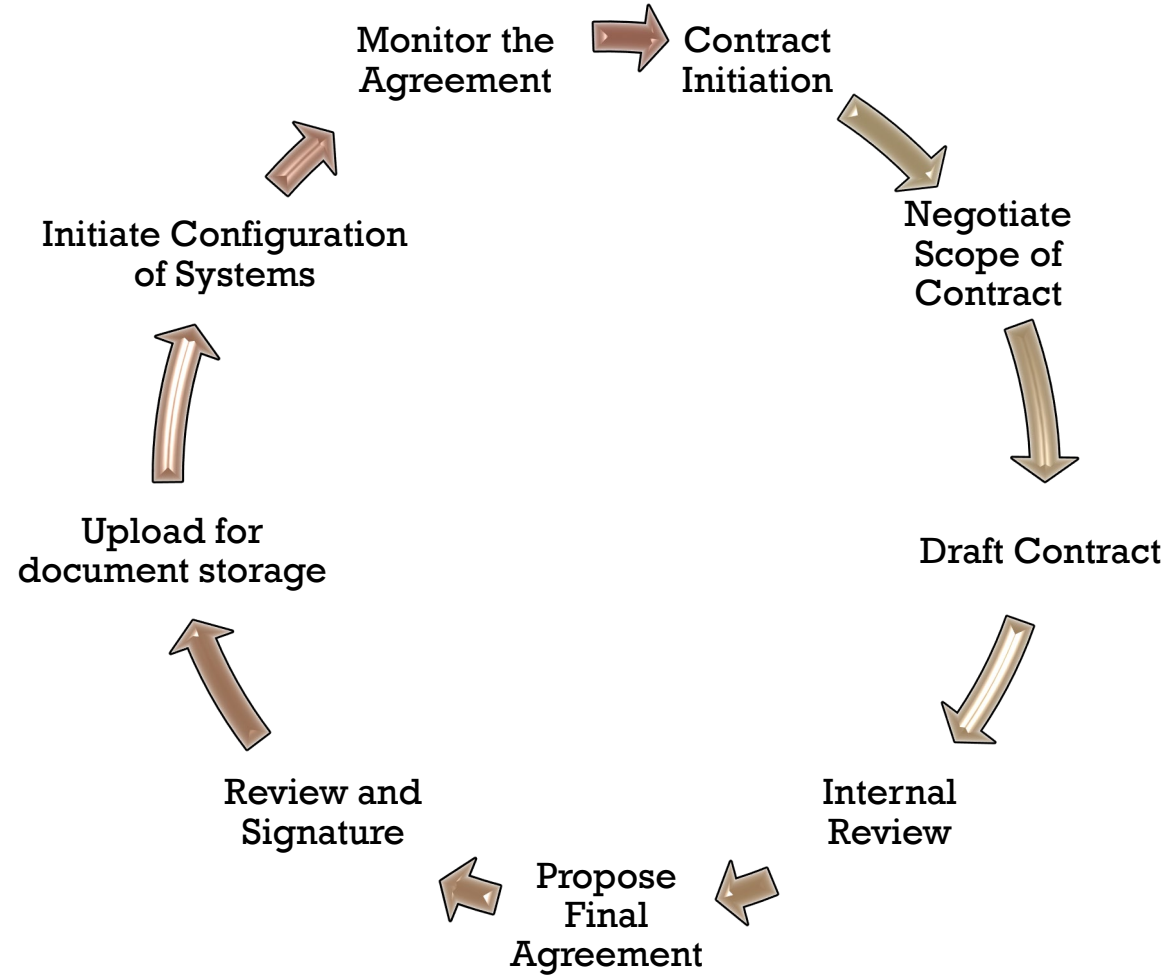
Key Documents Throughout Mankind and US History

- The Lord's Prayer – 66 words
- The Ten Commandments – 179 words
- Gettysburg Address – 286 words
- Declaration of Independence – 1,300 words
- Bill of Rights, including Preamble – 652 words
- United States Constitution – 4,543 words
- Managed Care Agreement ???????
 - 15,000 + words

Where premium dollars are going



CONTRACTING CYCLE



Revenue Enhancement – Offense

- Don't let payors say they will not negotiate
 - Question your legal counsel over a restriction of trade verbiage you can use that aligns with your practice
- Look to enhance net revenue and managed care portfolio
 - Contract renegotiations
 - Strategic contracting initiatives
- Value based contracting
- Evaluate direct employer contracting strategy
- ACA contracting

Revenue Protection – Defense

- Standardize contractual language
 - Identify language for standardization
 - Develop language to standardize operational & contractual language.
- Develop managed care management tools to track managed care volumes, net revenue, and other key performance indicators
- **Always** seek to make terms of contracts mutual

WHAT IS IN THE CONTRACT?

- In simplest terms, a managed care contract is an agreement between a healthcare professional and a managed care organization (MCO) that defines the relationship (both financially and care-wise)
 - Legal binding document that binds **both** parties
 - Definitions
 - Legal verbiage
 - Payment obligations
 - Utilization management process and requirements
 - Claims payment process
 - Termination process
 - Payment rates and provisions
 - Provider manual and other documents reference in the contract

WHAT IS NOT IN THE CONTRACT?

- Member benefit design
- Medical necessity determination
- The managed care organization(s) or self-funded employer processes
- Provider Manual, Policies, Procedures are referenced and referred into the contract, but not part of the agreement
 - **Always request, review, and understand how may impact contract document**
- Agreement may refer to other items that are referenced and referred into the contract
 - **Always request, review, and understand how may impact contract document**

KEY CONTRACT ELEMENTS

- As of September 28, 2023 (the list is already outdated)
- Definitions
 - These key words must be understood as they will be key verbiage governing agreement
- Notice
 - This is a key element to the agreement. Seems to be an innocuous part of the agreement, but has an enormous impact on the agreement
 - Focus on how notice can be given to each party
- Change Language
 - Negotiate how changes to agreement, fee schedules, provider manual, policies, procedures, etc. can be made
 - Not changes without mutual consent
- Utilization Management / Quality Management Processes
- Claims Payment
 - Timely filing
- Term Language
 - Without cause
 - Term individual product or payor

KEY CONTRACT ELEMENTS

- Audits
- Assignment
 - How can the agreement be assigned

Amendments

- How can the agreement be amended

Force Majeure

- "Force majeure" comes from the French phrase "superior force," and commercial contracts often contain a "force majeure" clause, the purpose of which is to relieve a party from its contractual duties when its performance has been prevented by a force beyond its control.
- Events
- "Acts"

Record Keeping

Member Agreement – FYI

KEY CONTRACT ELEMENTS

- Malpractice Requirements
- Dispute Resolution
 - How, when, where
- Patient Communication
- Fee Schedule
 - Type of fee schedule
 - CMS, Payor Specific, Proprietary, etc.
 - CMS or Payor Locale
 - Mid-levels
 - How are changes made
 - Default for non fee schedule codes
 - New codes
 - If you can't calculate it on the back of a napkin, then it's an ambiguous agreement / schedule

HOW TO ANALYZE PAYMENTS & EXPECTED REIMBURSEMENT

- Unless billed charges are less than allowable, providers do not get paid their charges on a claim
 - Annual analysis
- All payments from contracted plans are based on pre-negotiated payment amounts and methodologies
 - $\text{MCO payment} + \text{Patient portion (co-pay, deductible, co-insurance)} = \text{Total payment}$
- Always use expected reimbursement to analyze payments
 - $\text{Billed charges} - \text{calculated contractual adjustment} = \text{expected reimbursement}$
- When renegotiating agreements, **always** model each proposal and review each iteration of contract document

CLOSING COMMENTS

- Always Think “what if”
- Approach the negotiation from a ”mutual” perspective
 - If it’s a partnership, how can one partner ask something of the ”partner” that they would not agree to as well?
 - Points out the hypocrisy
- The only ask that is bad is the one you don’t make.
 - Like real estate three words, but different: “Ask, ask, ask”
- No is a word, just like yes. You want to hear more no’s and don’t be afraid to ask
- And finally, **you get what you negotiate**

OPEN DISCUSSION

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