

Managing Physical Rehabilitation in a Managed Care Environment

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Managing Physical Rehabilitation in a Managed Care Environment About the 2011 Revision

This book was originally written in the mid 1990's – a time of great turmoil for rehab professionals. It was also a time with much discussion of alternate delivery systems and re-structuring of the health care world. Sound familiar?

At the time, there was precious little written about managed care for the working therapy manager, practice owner or front line clinician. Managed care was seen as a big scary creature, poorly understood, but definitely ominous. Sound familiar?

Now it is 2011. What the Balanced Budget Act of 1997 was for the original edition of this book, the Affordable Care Act of 2010 is to this revision. What Managed Care Organizations were to the original edition, Accountable Care Organizations are to this revision. The vocabulary has changed substantially, the concepts have changed marginally.

As was the case in 1997, rehab professionals need to get up to speed on these concepts and work to assure the profession a place at the negotiation table as new forms of health care delivery are envisioned and implemented. To be left out of those discussions could prove disastrous for our professions.

In an effort to get this revision into the hands of those who need it most, we've made some rather unusual decisions related to this book:

- We are not creating an entire new publication, but rather editing OUT those parts that just are no longer relevant to today
- We are not creating a hardcopy version – only a PDF for quick and inexpensive distribution
- We are not selling this version – we are releasing it to the public domain under a Creative Commons License that allows anyone to distribute it as long as they don't sell it and as long as they credit it appropriately.
- We are posting the PDF to PTManagerBlog.com and PTManager list serve – both entities that did not even exist at all when the original edition was created.
- We are seeking feedback and discussion as thoroughly as possible in as timely a manner as possible because we believe the professions involved in rehab REALLY need to engage this discussion, understand the issues and background, and find a way to get to the table for discussions in integrated health systems – currently existing or otherwise.

Thanks for taking a look at this publication. We hope you find it valuable.

As always, we wish you all the best

Jake and Peter
3/1/2011

*This book is dedicated, with love,
to our children,
David Matthew Kovacek
Katharine Elizabeth Kovacek
and
Laura Jakubiak Kovacek
who represent our future and only
enduring legacy.*

Why an Entire Book on Managing Rehabilitation in a Managed Care Environment?

The past few years have seen tremendous changes in health care delivery systems. Many experts have attributed these changes to the growth of managed care. Although not all areas of physical rehabilitation are equally affected by managed care, no area of rehabilitation is immune from the effects of managed care. Throughout this book, we will attempt to provide a balance view of managed care and the physical rehabilitation industry. It is our belief that managed care is not inherently harmful or immoral. We do, however, strongly believe that the manner in which managers of rehabilitation practices approach the unique challenges and opportunities inherent in managed care will have a tremendous impact on the success of those practices. Throughout this book, we will attempt to present background information related to managed care and its impact on rehabilitation practices. We will, whenever possible, also try to identify the alternatives available to rehabilitation managers.

This book is designed to help you, the rehabilitation manager, student or aspiring rehabilitation manager, succeed in a rapidly changing healthcare world. Although, at times, a very complex and confusing area, managed care and reimbursement knowledge and skills are very important to your success as a manager, leader and clinician.

Who is this Book Intended For?

This book is intended for rehabilitation professionals, including physical therapists, occupational therapists, speech-language pathologists, rehabilitation nurses, physicians specializing in physical medicine, and professionals without a clinical background who may manage physical rehabilitation programs. This book is also intended for students in any of these areas.

Purpose

Our objectives in preparing this book are multiple. We hope that this book will help you:

1. Review the important concepts of managed care and reimbursement to help you in your rehabilitation practice.
2. Explore your thoughts and feelings about various reimbursement strategies and managed care in general.
3. Review incentives for specific clinical behaviors inherent in various reimbursement and managed care models.
4. Identify optimal clinical and managerial behaviors for financial return and clinical success.
5. Plan for future changes in your clinical behavior required by the continuously changing healthcare environment.
6. Develop an action plan that will allow you to thrive in the healthcare future.

References

A complete set of references to the topic of managed care and rehabilitation is included in the Appendix. Specific data referenced in the body of the book are from US governmental sources unless otherwise indicated.

Using This Book

Because parts of this book, especially the first chapter and the case studies, are formatted as a workbook, not all the answers will be given to you. You will need to work to find your own answers for some items. Many of the concepts presented do not lend themselves well to a singular best answer or strategy. In many cases, the best option depends on many factors that may be relatively unique to your setting and practice.

It is our hope that this combination of background information, review of implications and structured learning will help you manage your staff and practice better and ultimately promote success for your patients.

Your comments, criticisms and success stories are always welcome feedback. You may contact us via email through the primary author at:

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We wish you all the best.

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Overview

This chapter will help you and your staff examine your readiness for moving into managed care. We will survey each of the most critical management areas in the assessment process. You may choose to use all the assessments or just some of them. The choice is yours. We have included the most popular assessments for your use and to provide an initial discussion point with staff.

The areas of focus in self assessment are:

- \$ Defining Success
 - Optimal Quality
 - Quantity of Rehabilitation Services
 - Reimbursement
 - Cost Containment
- \$ Checking your Readiness for Change
- \$ Personnel Issues
 - Attitudes toward managed care, self-determination, productivity and quality care
 - Definitions of success, acceptable quantity and quality care
 - Knowledge of managed care and reimbursement
 - Non-hands-on clinical skills
 - Case Management
 - Delegation Skills
 - Negotiation Skills
 - Time Management
 - Productivity
 - Patient Education
 - Motivation to succeed in Managed Care
- \$ Your Current Clinical Environment
 - Payer Mix
 - Managed Care Penetration
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 - Managed Care Competition
 - Past History of Managed Care
 - Legislative Environment
 - Industry Changes in Managed Care
- \$ Business and Clinical Systems
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 - Previous Actions Taken to Address Managed Care
 - Profile of Patient Care
 - Treatment Guidelines
 - Clinical Care Report Card
 - Frequency and Dissemination of Data
 - Systems in Place
 - Financial Systems
 - Documentation Systems

- Patient Scheduling Systems
- Productivity Management Systems
- Outcomes Management Systems
- Quality Improvement Systems
- Third Party Relations
- \$ Information Systems
 - Data Collections
 - Types of Data Collected and Analyzed
 - Methods
 - Dissemination of Information
- \$ Commitment to Improvement
- \$ Developing a Plan for the Future

Defining Success

The conceptual model we will use for planning and measuring success will be based on four prerequisites to financial success as shown below.

We believe that although financial success is very desirable, it is not an end in itself. Rather, financial success is an enabler for many other types of success, including professional success, social success and personal success. However, it has been the experience of the authors that lack of financial success will interfere with these other types of success. Financial success is, therefore, necessary, but not sufficient for other more meaningful types of success.

The four components of financial success are both necessary and sufficient for financial success. They are also listed in order of importance: optimal quality, quantity, reimbursement and cost containment. We will review each of these in sequence.

Optimal Quality

In order for any of our work to matter, it requires that it be performed at a level that will allow optimal results. Even when performed at a level of excellence, some of the work we may do as rehabilitation clinicians may not be successful in helping our patients reach their goals. This may not be because we have performed the tasks incorrectly, it could be that our overall level of understanding of the effect of our actions is incomplete. As any rehabilitation professional knows, even the most highly skilled clinician is not completely successful 100% of the time. Clearly there remain aspects of our professional universe that we still do not clearly understand.

In spite of our incomplete knowledge regarding many of the factors in our practice, we still must attempt to provide the highest quality possible. To do otherwise would lack integrity. In doing less than optimal care, we would not be fulfilling our duty to our patients, a duty that should never be taken lightly. Without a high quality product to provide to our patients, there is really no need to be concerned about the other components of financial success. Quantity is not an issue when we provide poor quality. Increasing the volume of low quality services, only develops a larger universe of unsuccessful care.

Reimbursement for poor quality care creates a dilemma. Do we really have a right to pursue reimbursement when we are cognizant of the ineffectiveness of our services? Eventually, those who purchase our services will realize that they have little chance of success when done incorrectly. They will simply stop purchasing.

Cost containment is irrelevant when there is no product or service to sell. Therefore, the basis for all aspects of financial success must be optimal quality of care. This is true in all rehabilitation environments, including managed care. We will examine the critical components of quality improvement programs in Chapter 5.

Quantity of Rehabilitation Services

Once we have assured that high quality care is provided, we must attempt to create systems in our practices and skills in our staff that will allow a high volume of those services to be accomplished. Especially, in an environment such as rehabilitation where a high proportion of our costs are related to personnel who produce the work of the business, it is necessary to use those human resources efficiently and at a high volume. Throughout the mechanisms of reimbursement that are possible for rehabilitation services, it has always been possible to correlate the quantity of our work with the amount of our reimbursement. Capitation and risk sharing financial models have changed this relationship. Understanding how the rules have changed will be critical for the successful rehabilitation manager. We will examine issues related to mechanisms of reimbursement in Chapter 4 and productivity management programs in Chapter 5.

Reimbursement

A major emphasis of the managed care movement is toward changes in the manner in which health care services are reimbursed. An additional emphasis is to identify those health care services that are believed to be ineffective, wasteful or abusive. There are many nuances to reimbursement. Each venue of rehabilitation care along the health care continuum has a myriad of rules and regulations that must be addressed to successfully be reimbursed for care. To assure that your practice receives all the reimbursement due, it is necessary to develop a high level of reimbursement expertise. Although this book is not intended to be a primer on reimbursement, the issue must be carefully examined. A major focus of Chapters 4, 5 and 6 will be reimbursement issues.

Cost Containment

The final step in financial success is cost containment. This has always been true. However, with the increasing emphasis on risk sharing and pre-paid care for populations in fixed reimbursement arrangements, cost containment has gained even greater prominence. Regardless of the amount of reimbursement received, the successful practice must expend less than its operational revenues over time to attain financial success. Deficit spending is not a viable long term strategy - for either rehabilitation practices or governments. In a fixed reimbursement world, the only variable is expense. Cost containment is a primary method to enhance profitability. Cost containment will not be a major focus of this book.

Checking Your Readiness for Change

What is your current knowledge of insurance and payment methods for your patients is: (circle one)

- Excellent
- Pretty good
- OK
- Could be better
- Poor

Why? _____

What are the implications of your level of knowledge about reimbursement?

You think knowing about insurance and payment methods is: (circle one)

- Very important
- Somewhat important
- Not very important
- Not needed

Why ? _____

When you don't know enough about your patients' insurance and payment methods, the following can happen:

- 1
- 2
- 3
- 4
- 5
- 6
- 7

When you realize you don't know enough about your patients insurance and payment methods, you may feel...

- 1
- 2
- 3
- 4
- 5
- 6
- 7

Why ?

Your level of commitment to learning about reimbursement is:

- Very High
- Pretty high
- Not very high
- Neutral
- Pretty Low
- Very Low

Why ?

Patients deserve the best care possible because:

- 1
- 2
- 3
- 4
- 5

The best care possible can be described as:

- 1
- 2
- 3
- 4
- 5
- 6

When you are providing clinical care to patients, what is the highest volume of work that allows you to provide your highest quality of care?

What could be changed within your practice so that you could do more and still maintain your highest quality of care?

Why ?

A patient's care should be determined by:
(place in order of priority 1 to 4 with 1 most important)

- ___ The needs of that patient
- ___ The type and amount of care approved by the insurance company
- ___ The referring physician
- ___ The protocol or critical path we have for the patient's diagnosis

Why ?

How do you describe the relationship between your practice and the third party payers that you need to interact with?

Why ?

In the ideal, what would you want the relationship between your practice and the third party payers you interact with to be?

Why ?

Rate your self in each of the following areas now and where you want to be .
 (10 highest, 1 lowest). Then ask your manager to score your current skills and compare:

Skill	Current Score	Target Score	Manager=s Score of My Current Skills	Comments
Case Management Skills				
Delegation Skills				
Negotiation Skills				
Time Management Skills				
Clinical Productivity				
Patient Education Skills				
Other Skills I Need in Managed Care				

YOU are the SELF in Self- Assessment

Over the course of the next few pages, you will need to complete the charts for your own practice or clinic to develop a database of information for your reference as you proceed through the rest of the book. Completing these charts will be most helpful, however, not completing them will not preclude you from benefitting from the remainder of the book.

Assessing Your Current Clinical Environment

Sample Payer Mix

What is Your Payer Mix?

Indemnity _____

HMO _____

PPO _____

POS _____

Capitated _____

Cost Reimbursed _____

Charity _____

Other _____

Who are Your Managed Care Payers? How Much Business From Each?

What are your trends in managed care penetration?

Sample MCO Penetration Trend

What is your overall Managed Care Organization Trend?

What is your Health Maintenance Organization Trend?

What is your Preferred Provider Organization Trend?

What is your Point of Service Plan Trend?

What is Your Capitation or Risk Sharing Trend?

What is your trend in other Managed Care Organization relationships, if any?

Additional areas of concern within your environment are the industry itself and any legislative actions that will affect your practice. Note those below for future reference.

Changes in the Rehabilitation industry in our area that may affect our practice are:

Why ?

Changes in Federal, State or Local legislation that may affect our practice are:

Why ?

Patient Type Mix

Sample Patient Mix

What is your Patient Mix?

Orthopedic _____

Pediatric _____

Other (Specify) _____

Neurologic _____

Spinal Cord Injury _____

Other (Specify) _____

Wound Care _____

Traumatic Brain Injury _____

Other (Specify) _____

Patient Care Setting

Sample Patient Care Setting Mix

What Is the Mix of Patient Care Setting in Your Continuum of Care?

Acute Hospital _____

Skilled Nursing Facility _____

Outpatient _____

Home Care _____

Rehab Unit or Hospital _____

Sub Acute Unit _____

Other (Specify) _____

Other (Specify) _____

Other

(Specify) _____

What are the typical types of treatment that are provided to patients in your clinic? Specify for your top 5 patient classifications.

Sample

Patient type:Adult Low Back Pain Patients

Number of visits average:6-8

Average treatment duration:14 calendar days

Total Charges:\$485.00

Patient type : _____

Number of visits average _____

Average treatment duration (days) _____

Total Charges _____

Patient type : _____

Number of visits average _____

Average treatment duration (days) _____

Total Charges _____

Patient type : _____

Number of visits average _____

Average treatment duration (days) _____

Total Charges _____

Patient type : _____

Number of visits average _____

Average treatment duration (days) _____

Total Charges _____

Patient type : _____

Number of visits average _____

Average treatment duration (days) _____

Total Charges _____

Do you have any information on competitor data for these types of patients?

Where do you stand in your competitive market for cost of care and intensity of services?

Which of the following do you use in your practice? (Check all that apply)

--	--	--

	Currently Use	Plan to use within 1 year
Treatment guidelines		
Outcomes management system		
Clinical care report cards		
Automated documentation systems		
Automated patient schedule reporting systems		
Productivity management systems		
Quality management systems		

Rate your information systems on the following factors (1-10, 10 highest).

Factor	Ease of Use	Ease of Learning	Report Quality	Access	Reliability
Patient data entry					
Patient data editing					
Patient data tracking					
Financial reporting					
Billing entry					
Coding verification					
Insurance information					
Insurance verification					
Credit verification					

Collections information					
-------------------------	--	--	--	--	--

Developing a Plan for Action

Pre-assessment - Complete this section prior to reviewing or reading the remainder of this book.

What New Skills Will You Need to Thrive in a Managed Care Environment?

What Will Need to Change in Your Organization to Thrive in a Managed Care Environment?

What Actions Will You Need to Take to Acquire These New Skills?

Who Will Need to Assist and Support You and Your Organization as You Take Actions to Acquire the New Skills for Managed Care?

Overview of Managed Care

Overview

In order to understand the challenges that a specific component of health care providers, rehabilitation providers, faces in a managed care world, we will need to examine the generic world of managed care. In this chapter we will review the history and development of managed care, describe the most common types of managed care and discuss the various kinds of interfaces that are required. We will also introduce some of the key concepts of managed care and contrast managed care to the traditional health care system.

Preview of Major Topics

Where did Managed Care Come from?

The Traditional Health Care System

Traditional Health Care Financing

Purchasers of Health Care

- Government

- Employers

- Insurance Organizations

- Purchasing Pools

- Sub Contracts

What is Different in Managed Care?

Defining Managed Care

How Does Managed Care Work?

Appealing a Decision by Managed Care Organizations

What are the Advantages of Joining a Managed Care Plan?

What are the Disadvantages of Joining a Managed Care Plan?

Managed Care Financing

Traditional Health Care Compared to Managed Care

How Managed Care Pays Providers

Sharing Financial Risk

Capitation

What is the future likely to bring in managed care?

Case Study: How Much is Enough?

Where Did Managed Care Come From?

Managed care evolved from traditional health care, which lacked the organized systems that managed care possesses. Since early in this century, health care issues have continued to escalate in importance. Beginning in 1915, various efforts to establish government health insurance programs have been initiated every few years. From the 1930s on, there was broad agreement on the real need for some form of health insurance to alleviate the unpredictable and uneven incidence of medical costs. The main health care issue at that time was whether health insurance should be privately or publicly financed.

NATIONAL HEALTH EXPENDITURES BY SOURCE OF FUNDS,
1990-1995 (By calendar year)

Source of Funds	1990	1991	1992	1993	1994	1995
In Billions of Dollars						
All National Health Expenditures	697.5	761.7	834.2	892.1	937.1	988.5
Private	413.1	441.4	478.8	505.5	517.3	532.1
Private health insurance	232.4	252.3	277.0	295.4	302.7	310.6
Out-of-pocket payments	148.4	155.0	165.8	171.6	176.0	182.6
Other private funds	32.3	34.1	36.0	38.5	38.6	38.9
Government	284.3	320.3	355.4	386.5	419.9	456.4
Federal	195.8	224.4	253.9	277.6	301.9	328.4
Medicare	112.1	123.0	138.3	150.9	167.6	187.0
State and local	88.5	95.9	101.6	108.9	118.0	128.0

Percentage Change from Previous Year

All National Health Expenditures	12.1	9.2	9.5	6.9	5.1	5.5
Private	11.7	6.8	8.5	5.6	2.3	2.9
Private health insurance	14.1	8.6	9.8	6.6	2.5	2.6
Out-of-pocket payments	9.0	4.4	7.0	3.5	2.6	3.7
Other private funds	8.1	5.6	5.5	7.1	0.1	0.8
Government	12.7	12.7	11.0	8.7	8.6	8.7
Federal	12.0	14.6	13.1	9.4	8.7	8.8
Medicare	9.4	9.7	12.4	9.1	11.0	11.6
State and local	14.5	8.3	6.0	7.2	8.4	8.4

SOURCE: Congressional Budget Office based on data from the Health Care Financing Administration, Office of the Actuary.

Private health insurance coverage expanded rapidly during World War II, when employee benefits were increased to compensate for government limits on direct wage increases. This trend continued after the war, in part due to the favorable tax treatment of providing compensation in the form of employee benefits. Private health insurance (mostly group insurance financed through the employment relationship) was especially needed and wanted by

middle-income people. Yet not everyone could obtain or afford private health insurance. Government involvement was sought. Various national health insurance plans, financed by payroll taxes, were proposed in

Congress starting in the 1940s; however, none was ever brought to a vote.

In 1950, Congress acted to improve access to medical care for needy persons who were receiving public assistance. This permitted, for the first time, Federal participation in the financing of State payments to the providers of medical care for costs incurred by public assistance recipients. In 1960, the Kerr-Mills bill provided

medical assistance for aged persons who were not so poor, yet still needed assistance with medical expenses.

But a more comprehensive improvement in the provision of medical care, especially for the elderly, became a major congressional priority.

After consideration of various approaches, and after lengthy national debate, Congress passed legislation in

1965 establishing the Medicare and the Medicaid programs as Title XVIII and Title XIX of the Social Security

Act. Medicare was established in response to the specific medical care needs of the elderly (and in 1972, the

severely disabled and certain persons with kidney disease). Medicaid was established in response to the widely perceived inadequacy of "welfare medical care" under public assistance. In 1977, the Health Care Financing Administration (HCFA) was established under the Department of Health and Human Services to administer the Medicare and Medicaid programs.

ANNUAL GROWTH OF PROVIDERS' REVENUES AND COSTS,
 1990-1996 (By calendar year, in percent)

	1990	1991	1992	1993	1994	1995	1996 ^a
Community Hospital Revenues	10.9	10.3	9.4	7.1	4.9	5.0	3.7
Inpatient	8.7	8.2	7.3	5.7	2.5	2.6	0.7
Outpatient	18.4	18.0	15.6	10.6	10.1	9.9	9.1
Other	11.7	7.2	10.1	9.1	9.9	10.4	11.2
Labor Costs for Health							
Establishments Based on the CES							
Payroll	10.0	9.0	7.3	5.5	4.4	4.8	n.a.
Hours worked	3.9	3.5	3.2	2.0	1.6	1.9	n.a.
Average hourly wage	4.8	4.1	2.7	2.4	1.7	1.9	n.a.
Adjusted Milliman and Robertson							
Health Cost Index ^b	10.9	7.7	8.4	4.3	3.1	3.2	n.a.
Memorandum:							
Average Hourly Wage, All Industries	2.7	1.9	1.3	1.4	1.7	2.0	n.a.

SOURCE: Congressional Budget Office based on the American Hospital Association's National Hospital Panel Survey; and Paul B. Ginsberg and Jeremy D. Pickreign, "Tracking Health Care Costs," *Health Affairs*, vol. 15, no. 3 (Fall 1996), pp. 140-149.

NOTE: CES = Survey of Current Employment Statistics (conducted by the Bureau of Labor Statistics); n.a. = not available.

- a. Based on data through September 1996.
- b. Ginsberg and Pickreign adjusted the index to include Medicare spending.

Subsequent to their enactment, both Medicare and Medicaid have been subject to numerous legislative and administrative changes designed to make improvements, with financial considerations, in the provision of health care services to the aged, disabled and poor. Since 1965, growth rates in health care expenditures have consistently outpaced growth in general revenues for all levels of government. National data for calendar year (CY) 1995 show that the Nation's health care bill totaled \$988.5 billion for the 273 million persons residing in the United States. The 1995 total health care spending within our country amounted to \$3,621 per person, -- 5.5 percent higher than in 1994.

Managed care began with the advent of Kaiser Health Plan during World War II, with clinic based systems. The Medicare and Medicaid Acts in the 1960=s helped fuel a continuous explosion in health care costs, and managed care was seen as one solution. The Health Maintenance Organization act of 1973 paved the way for growth, and conversion of Health Maintenance Organizations to publicly held companies in the 1980=s and 1990=s supplied capital to accelerate growth.

Traditional health care has changed dramatically. As we approach the new millennium, the incidence of traditional indemnity insurance continues to drop. In an environment where the consumer is often not adequately knowledgeable to make informed decisions about health care quality, decisions are often made based solely on price. Managed care is a less expensive alternative to traditional health care. This is true at least in the short term. Long term costs to the patient (also referred to as a subscriber or member) and to society overall are not yet known.

The Traditional Health Care System

A traditional system may be a misnomer: Traditional health care could be defined as lacking a system. In traditional health care, the patient-physician relationship is the focal point. Purchasers are somewhat passive third parties, paying for the services a physician orders, often at the provider=s usual charges. The basis for traditional health care is the third party system. (See Chart) These parties are the patient (Party 1), the provider (Party 2), and the payer (Party 3). A key thing to remember is the three-way relationship between the patients, providers and payers. Patients who receive care, from providers who give the care, and get paid by purchasers or payers who insure the care on behalf of the patients. A provider is a health care professional or facility such as a physician, hospital, physical therapy clinic, pharmacy, laboratory, etc. The payer is who pays for care such as an employer, government and insurance organization. The chart below shows the relationships of these parties to each other and to the regulatory environment in which all three exist. The additional player (fourth party) in the third party system is the regulatory system which governs the health care being delivered. Typically, this fourth party is a local, state or federal government agency such as the State Insurance Commissioner, State Department of Public Health, Bureau of Workers= Compensation, or Health Care Finance Administration.

A cornerstone of traditional health care is freedom of choice for patients and physicians. Patients can choose whatever provider they want to see and physicians can choose to order whatever services they feel are necessary.

Traditional Health Care Financing

Under the traditional health care system, the patient can choose any licensed physician and use the services of any hospital, health care provider or facility which participates in and accepts the insurance

program. Generally, a fee is paid each time a service is used. This is called the fee-for-service system. Typical insurance pays a share of hospital, doctor, and other health care expenses. The patient may be responsible for certain deductibles and coinsurance payments--the portion of the bill insurance does not pay. The patient must also pay all permissible charges in excess of approved amounts as well as charges for services not covered. In managed Medicare or managed Medicaid, some of those potential out-of-pocket costs can be avoided or reduced through the purchase of private insurance to supplement typical insurance. This is called "gap" insurance. Gap insurance is specifically designed to close some of the payment gaps in coverage. These are very common in the Medicare program. Gap insurance is often called the secondary insurance, e.g. secondary to Medicare as primary insurer.

ANNUAL GROWTH OF PREMIUMS OR COSTS FOR
 EMPLOYMENT-BASED HEALTH INSURANCE, 1990-1996

(By calendar year, in percent)

Source	1990	1991	1992	1993	1994	1995	1996
Hay/Huggins ^a	17	13	12	8	3	1	-3
Foster Higgins ^b	17	12	10	8	-1	2	2
KPMG Peat Marwick ^c	n.a.	12	11	8	5	2	d
Bureau of Labor Statistics ^e	11	11	9	7	4	d	d

Notes:

Consumer Price Index for All

Urban Consumers	5.4	4.2	3.0	3.0	2.6	2.8	2.9
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SOURCE:

Congressional Budget Office based on the sources

cited below.

NOTE: n.a. = not available.

- a. Hay/Huggins, *Benefits Report* (Washington, D.C.: Hay/Huggins, 1990 through 1996). The surveys use average premiums for all employers for the most prevalent plan, based on a sample of public and private employers that generally have at least 100 employees.
- b. Foster Higgins, *National Survey of Employer-Sponsored Health Plans* (New York: Foster Higgins, 1990 through 1996). The surveys are based on a sample of private and public employers with 10 or more employees.
- c. KPMG Peat Marwick, *Health Benefits* (n.p.: KPMG Peat Marwick, 1990 through 1996). The surveys are based on a sample of private and public employers with 200 or more employees.
- d. Growth of 0.5 percent or less.
- e. The employment cost index compiled by the Department of Labor's Bureau of Labor Statistics. The index covers only the employers' share of premiums or costs. Growth rates measure changes in cost over a 12-month period from December to December.

Purchasers of Healthcare

How are health care services purchased?

- § Patients can be uninsured and pay directly for services.
- § Patients can receive care through a government program such as Workers= Compensation, Medicare or Medicaid.
- § Patients can pay premiums to health plans to provide coverage.
- § An organization can self-insure for coverage.
- § Health plans pay providers and provider organizations.
- § Purchasing pools can arrange care through health plans.
- § Provider organizations can buy care through subcontracts.

We will now examine each of these possibilities in further detail.

PRIVATE HEALTH EXPENDITURES BY SPONSOR, 1990-1994
 (By calendar year)

	1990	1991	1992	1993	1994
In Billions of Dollars					
Employers' Contributions for Private Health Insurance Premiums ^a	181.1	194.5	213.0	228.2	242.7
Employees' Contributions for Private Health Insurance Premiums ^a	33.3	37.5	40.4	44.1	47.7
Individual-Policy Premiums ^a	18.0	19.9	23.2	24.2	22.9
Out-of-Pocket Spending	148.4	155.1	164.4	169.4	174.9

Percentage Change from Previous Year

Employers' Contributions for Private Health Insurance Premiums ^a	14.7	7.4	9.5	7.2	6.3
Employees' Contributions for Private Health Insurance Premiums ^a	16.0	12.5	7.9	9.0	8.2
Individual-Policy Premiums ^a	5.0	10.7	16.5	4.3	-5.1
Out-of-Pocket Spending	n.a.	4.5	6.0	3.0	3.2

SOURCE: Cathy A. Cowan and others, "Business, Households, and Government: Health Spending, 1994," *Health Care Financing Review*, vol. 17, no. 4 (Summer 1996), pp. 157-178.

a. Includes private health insurance expenditures for personal health care plus the net cost of private insurance.

Government

Government is the largest purchaser of health care, serving as an insurance organization for traditional Medicare, Medicaid & Champus (Civilian Health and Medical Program for the Uniformed Services - a program for eligible military care). State and Local government can also be an employer that self-insures or pays insurance premiums for government employees. Some government employees are also covered under a purchasing pool for Managed Care Organizations (MCOs). An example of a direct contractor providing care through government agency is the Veterans Administration.

Employers

If health care is employment based, an employer, union or trade organization has arranged health benefit coverage. There are several ways this can be done:

- § They might purchase coverage from one or more insurance plans.
- § They might belong to a coalition or purchasing pool that negotiates and or arranges purchasing coverage from plans.
- § They might choose to self-insure. Instead of paying premiums, they would set aside financial reserves to pay claims from providers. They might contract with a third party administrator (TPA) to process these claims and manage the self-insurance.

Insurance Organizations

An insurance organization could be an insurance company or Managed Care Organization; and could be a health, dental or other specialty plan. An insurance organization offers a plan of covered benefits (policy) to members, and charges a specific dollar amount (premiums) for the plan. Plans can be offered on an individual basis, as group policies for employment-based coverage and under contract with the government. Insurance organizations bear the financial risk of paying providers.

Purchasing Pools

Sometimes employers or unions form coalitions to collectively negotiate premiums and benefits with insurance organizations, but each coalition member still buys a separate policy for its organization under these negotiated terms. Purchasing pools also negotiate and arrange coverage with one or more insurance organizations for multiple employers, unions, etc. The difference is that the policy is issued to the purchasing pool, not each organization buying coverage from the pool. The purchasing pool must administer the offering of available plans, the collection of premiums from member organizations, and premium payments to the plans.

Subcontracts

As an example of a subcontract arrangement, provider organizations may enter into subcontracts with other health care agencies to provide specific types of care to members under the provider organization's contract with a Purchaser. In these cases, the provider organization is negotiating contracts with providers and purchasing their services, just as a Health Maintenance Organization will purchase services from the provider organization.

NATIONAL HEALTH EXPENDITURES IN 1995, BY TYPE OF EXPENDITURE AND SOURCE OF FUNDS
(In billions of dollars)

Type of Expenditure	Total Spending	All Private Spending	Private Spending By Consumers			Other Private Spending	Government Spending		
			Total	Out of Pocket	Private Insurance		All Government Spending	Federal	State and Local
National Health Expenditures	988.5	532.1	493.2	182.6	310.6	38.9	456.4	328.4	128.0
Health Services and Supplies	957.8	521.2	493.2	182.6	310.6	28.0	436.7	314.4	122.2
Personal health care	878.8	486.7	459.3	182.6	276.8	27.3	392.1	303.6	88.5
Hospital care	350.1	135.8	124.5	11.4	113.1	11.3	214.3	175.3	39.0
Physicians' services	201.6	137.6	133.9	36.9	97.0	3.7	64.0	50.9	13.1
Dental services	45.8	44.0	43.8	21.8	22.0	0.2	1.8	1.0	0.8
Other professional services	52.6	39.9	36.0	20.2	15.8	3.9	12.7	9.6	3.1
Home health care	28.6	12.8	9.3	6.0	3.3	3.4	15.8	13.8	2.0
Drugs and other nondurable medical items	83.4	72.0	72.0	49.8	22.1	n.a.	11.4	5.9	5.6
Vision products and other durable medical items	13.8	8.7	8.7	7.8	0.9	n.a.	5.1	5.0	0.1
Nursing home care	77.9	32.6	31.1	28.6	2.5	1.5	45.3	29.3	16.0
Other personal health care	25.0	3.3	n.a.	n.a.	n.a.	3.3	21.7	12.8	8.9
Program administration and net cost of private health insurance	47.7	34.5	33.9	n.a.	33.9	0.6	13.2	7.1	6.1
Government public health activities	31.4	n.a.	n.a.	n.a.	n.a.	n.a.	31.4	3.8	27.6
Research and Construction	30.7	10.9	n.a.	n.a.	n.a.	10.9	19.7	14.0	5.7
Research	16.6	1.4	n.a.	n.a.	n.a.	1.4	15.2	12.9	2.3
Construction	14.0	9.6	n.a.	n.a.	n.a.	9.6	4.5	1.1	3.4

SOURCE: Congressional Budget Office based on data from the Health Care Financing Administration, Office of the Actuary.

NOTE: n.a. = not applicable.

What is Different in Managed Care?

To establish a purchaser's costs or premiums, multiple criteria should be considered. Prior cost experience of a given insured population, available medical management data (e.g. actuary charts) and how providers are paid in the locale all help establish a purchaser's premium. In managed care, the purchaser is actively involved in the delivery system. The choice of providers and the services that physicians order are subject to plan rules and regulations. In managed care programs, providers are organized in some manner, financial risk is spread to both payer and provider and there is some blending of the payer and provider role.

Managed care penetration is inconsistent. Throughout the nation, there are intense pockets of managed care (CA, MA, OR) and areas with relatively little managed care penetration (WY, AK, ID, ND, MS, SD). The chart above and the table below show the US with Percent Managed Care penetration by state in 1996 according to Medical Data International.

1996 Managed Care % Penetration by State

AK	0	HI	21	ME	3	NJ	22	SD	3
AL	9	IA	8	MI	22	NM	17	TN	10
AR	5	ID	2	MN	28	NV	19	TX	18
AZ	23	IL	17	MO	20	NY	30	UT	32
CA	46	IN	10	MS	2	OH	19	VA	14
CO	31	KS	6	MT	3	OK	9	VT	15
CT	24	KY	27	NC	5	OR	45	WA	18
DE	25	LA	10	ND	1	PA	25	WI	24
FL	25	MA	30	NE	12	RI	34	WV	5
GA	11	MD	24	NH	30	SC	6	WY	19

Defining Managed Care

What is managed care? It seems that the definition of managed care depends on whom you ask. We've included a number of the various definitions in this book. Part of the confusion comes from the rapid evolution of managed care. An additional complication is that multiple forms of each of the major types of managed care exist.

The Health Insurance Association of America defines managed care as:

Systems that integrate the financing & delivery of appropriate healthcare services to covered individuals by means of the following elements:

- § Arrangements with selected providers
- § Standards of selection of providers
- § Formal Quality Assurance and Utilization Management systems
- § Financial incentives for membership.

Clearly, a wide variety of forms of managed care can exist within this definition. Later, we will examine many of the most common structures and formats for delivering health care, and specifically, physical rehabilitation in a managed care model. Chapter 3 will focus on the various forms of managed care.

How Does Managed Care Work?

Managed care plans might be thought of as a combination insurance company and a health care delivery system. Like an insurance company, they cover health care costs in return for a premium, and like a doctor or hospital, they provide health care services. In addition to being called managed care plans, they also are known as prepaid or coordinated care plans, or just (inappropriately) Health Maintenance Organizations (HMOs).

Plans may have their own network of hospitals, skilled nursing facilities, doctors and other health care professionals. Services may need to be obtained from the professionals and facilities that are part of the plan.

Depending on how the plan is organized, the services are provided either at one or more centrally located health facilities or in the private practice offices of the doctors and other health care professionals affiliated with the plan.

Plans may charge enrollees a monthly premium, which can vary from plan to plan and is subject to change annually.

In addition to a monthly premium, plans commonly charge a small copayment for each appointment and drug prescription. Copayments typically range from \$5 to \$15. If the patient stays within the network of providers approved by the plan, there are usually no additional charges by the plan no matter how many services the patient receives. In some models, if the patient goes outside the plan for services, the plan may choose to not pay for those services. The patient will have to pay the entire bill out of pocket. In the Health Maintenance Organization model, the only exceptions are for emergency services, which the patient may receive anywhere in the United States, and urgently needed care, which the patient may receive while temporarily away from the plan's service area. If the patient receives emergency or urgently needed care, the doctor or hospital that provides the service will either bill the patient or plan.

In addition to paying for emergency and urgently needed care received outside the plan, a few risk plans offer what is called a "point-of-service" (POS) option. Under the POS option, the plan permits the patient to receive certain services outside the plan's provider network and the plan will pay a percentage of the

charges. In return for this flexibility, patients should expect to pay a larger percent of the bill. Managed Care Organizations may also offer extra benefits not otherwise covered by traditional health insurance. The extra benefits can include, for example, physical exams, scheduled inoculations and other preventive care, prescription drugs, dental care, hearing aids and eyeglasses, as well as coverage for overseas travel. Most managed care plans require the patient to select a primary care doctor from those affiliated with the plan at the time of enrollment. If the patient fails to make a primary care selection, a primary physician may be assigned.

Usually, primary care doctors manage their patients' medical and hospital care. If for any reason the patient wants to change their primary care doctor, the plan generally allow it as long as another one of the plan's primary care doctors is chosen.

Managed care plans have doctors available in all specialties of medicine. However, to see a specialist, patients must usually be referred by their primary care physician if the plan is to pay for the specialist's services.

Just as a plan arranges in advance with specific doctors to care for members, it generally has contracts with specific hospitals, skilled nursing facilities, physical and occupational therapy and speech-language pathology providers, home health care agencies and other health care providers to serve its members. Some of the larger plans, however, have their own hospitals and other health care facilities.

Theoretically, by coordinating primary, specialty, inpatient, and outpatient treatment, plans can deliver appropriate care while minimizing duplicative and unwarranted services.

Appealing a Decision by Managed Care Organizations

Managed care plans have a system to appeal payment decisions. Patients can file an appeal if the plan:

- Refuses to pay for covered services;
- Refuses to provide services requested; or
- Decides not to pay for care received from doctors or hospitals who are not part of the plan because the plan determined that the care was not for emergency or out-of-area urgent care.

Patients who believe that care should be paid for or provided, and it was not, should file a request for reconsideration by the plan. Plan membership materials usually give details on appeal rights.

What are the Advantages to the Patient of Joining a Managed Care Plan?

People join managed care plans for several reasons. Some of the most frequently mentioned include:

- § It can be easier to get all services through one source (e.g., doctors' services, hospital care, lab tests)
- § Theoretically, there is less paperwork for the patient.
- § Quality of care may be enhanced because of the coordination of services.
- § It may be easier to budget medical costs because the amount of premium is known in advance, and the total of other out-of-pocket expenses is likely to be less than under the fee-for-service system.
- § Patients generally pay only a nominal copayment when they use a service. Some plans do not charge copayments for certain specified services.
- § For Medicare beneficiaries, benefits beyond those covered by Medicare are available at either no additional charge or a nominal charge. Patients do not need Medigap insurance (secondary insurance) to supplement Medicare coverage because the plan provides all or most of the same benefits at no additional cost. Paperwork is virtually eliminated.

What are the Disadvantages of Joining a Managed Care Plan?

The disadvantages of enrolling in a managed care plan include:

- § Patients may not be free to go to any physician or hospital. Except when patients need emergency or unforeseen out-of-area urgent care services, they generally must use the plan=s providers or else the plan will not pay.
- § Patients may need to have the prior approval of their primary physician to see a specialist, have elective surgery, or obtain equipment or other medical services.

Managed Care Financing

In a managed care model, before providers order or render services, they must ensure they have the necessary approvals (if required). Contracted providers must accept assignment of fees. Contracted providers can not bill the patient the balance and not make the patient pay the difference between the provider charges and the amount the provider contractually agreed to take as payment in full for covered benefits. Members must still pay for their cost sharing. This contribution by the member can come from coinsurance costs, copays, or deductibles. The ways providers get paid vary greatly in managed care. Often provider organizations, for example, contract with Purchasers, and then, in turn, pay individual providers to deliver care.

Traditional Health Care Compared to Managed Care

At times, it can be very difficult to clearly define managed care models. One thing that seems to be very clear is that, in the short term, managed care is less expensive to the purchaser than traditional care. Long term cost data are seriously lacking so far. Within the spectrum of managed care models, there are also significant differences in overall cost. There are many possible reasons for the reduction in costs in managed care models. The following list identifies those factors, inherent to many managed care delivery models, that may be responsible for the lower short term costs seen in managed care:

- \$ Elimination of unnecessary or wasteful health care services
- \$ Alternative lower cost health care services and products to replace those of higher cost, e.g. generic drugs
- \$ Prevention of urgent and emergency crises
- \$ Provision of care at lower cost venues
- \$ Provision of care by lower cost personnel
- \$ Higher productivity levels of personnel, therefore requiring fewer personnel
- \$ Competitive bidding for price of health care services
- \$ Utilization management of high cost and high volume items
- \$ Clinical pathways, critical paths, care maps, treatment guidelines

How Managed Care Pays Providers

There are a myriad of mechanisms available to managed care organizations for reimbursing health care providers. These options will be listed here and explained further in Chapter 4 of this book. The specific mechanism of reimbursement will vary by Managed Care Organization and clinical setting. Options for reimbursement mechanism include:

- \$ Cost reimbursement
- \$ Fee for service at charged rate
- \$ Fee for service at discounted rate via fee schedule
- \$ Prospective payment, including per diem rate, case rate, diagnostic related groupings (DRG), or episode of care rate
- \$ Full risk capitation
- \$ Employment of the providers
- \$ Joint venture with the providers
- \$ Risk sharing ventures with the providers
- \$ Combinations of the above choices

Chapter 4, Reimbursement Methodologies in Rehabilitation, will examine each of these financial relationships in detail. For now, we only list them for completeness.

Sharing Financial Risk

One of the key components of managed care is the shifting of financial risk to the provider of the care. In Managed Care Organization provider contracts, providers often bear some level of financial risk. This is very desirable to the Managed Care Organization. Due to structure and regulations, Preferred Provider Organizations have the least risk sharing, exclusive provider organizations (EPOs) more, and Health Maintenance Organizations the most.

Capitation, the highest level of provider risk is usually only found in Health Maintenance Organizations.

Per case payments also involve some risk, as costs could exceed the case payment. Other types of risk sharing include withholds, when a portion of the provider payment is held back and only paid later if certain criteria are met. Also, there are shared risk funds, where provider groups share in a portion of the financial risk and potential profit of hospital or prescription costs.

Capitation

Capitation means paying a fixed amount of money per member or person (per capita) in the capitation pool. Capitation puts a lid on payments per member that otherwise might fluctuate under a fee-for-service system. Providers are at full financial risk for the services capitated. Capitation isn't the same as getting a fixed salary. Typically, the more members in the pool, the more revenue to start with. When providers examine capitation, they need to total revenue and costs for all their members. Instead of saying I was paid \$10 capitation for John Smith and gave \$100 worth of services, it is better to consider, I was paid \$1,000 for 100 capitated members, and combined they used \$x of services. This is not just a matter of semantics, it is a matter of philosophy. This may preclude some from considering capitation agreements.

What is the future likely to bring in managed care?

The future of managed care will be more fully reviewed in Chapter 8. For now, the rehabilitation manager will do well to ask the following questions:

What are the barriers to further managed care growth?

What is continuing to drive managed care?

What can a rehabilitation manager do to succeed in an intensifying managed care environment?

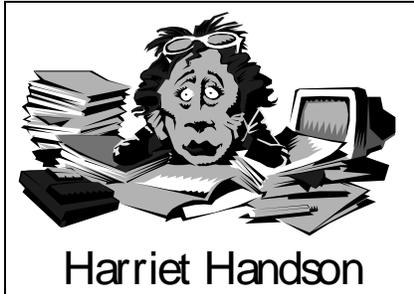
As we prepare to move to Chapter 3 - Types of Managed Care Organizations and review the intimate details of how managed care works, it is clear that the future of rehabilitation in a managed care world includes the following four realities. We will address each in greater detail in Chapter 8.

Increased accountability

Increased productivity

Increased emphasis on outcomes

Increased standardization.



Case Study How Much is Enough?

The Background

Harriet Handson is a senior therapist at Good Hands Hospital. She has worked at GHH for over 15 years and is highly respected by her peers. Over the past few years, Harriet has attended many clinical continuing education courses and has attained Aspecialist@ ranking within her professional association.

Harriet Handson is very proud of her accomplishments as a clinician and has always felt supported by her boss, Robert. Robert is an experienced manager who considers Harriet one of the finest therapists he has ever met. In the past, when someone in Robert=s family (including his beloved Grandmother) needed therapy, Harriet was the therapist Robert asked to cover them.

Recently, there has been much change at GHH. Managed care contracts have come to seemingly dominate the market. The current and projected mix of payors for GHH is shown below:

	Cost Reimbursed	Fee for Service	Managed Care - HMO/PPO	Managed Care - Capitated
Current	40%	15%	25%	20%
Projected in 12 months	20%	5%	40%	35%

Robert was involved in preparing these projections and feels that they are accurate. He is actively working to prepare his staff to make the transition to this new environment. The primary areas that Robert has worked on with his staff are:

- Clinical efficiency and outcomes analysis

- Therapist extenders - using ancillary staff and encouraging patient compliance with HEP

- Reduction of documentation and non-treatment time

After last month=s inservice on AClinical Techniques to Increase Therapist Efficiency@ that the staff attended there has been a dramatic increase in staff productivity. All of the staff seem to be willing to try new ways and seem motivated to learn. Until this morning, all the preparations were going well.

The Crisis

In reviewing the individual productivity of his staff, Robert notices that Harriet is the only staff member that has not improved in the last month. Her current patient load is only 60% of the current standard in place. In preparation for the changing payor mix, the staff has agreed to move to a new standard. When the standards are increased in 6 months, she will only be at 40% of that target. All the other therapists in this clinic are at least at 95% of the current standard. Many therapist are already at the new standard.

To try to understand the situation, Robert asks Harriet for a meeting. During the meeting the following facts come out.

Harriet feels that she is an outstanding therapist and is not willing to Awater down@ her treatments or adopt many of the suggested new practices or techniques

Harriet does not feel that the new standards are realistic for her and just does not Abuy into them@

Harriet believes it is unethical to treat in a different manner just because some patients have different insurance coverage - AAll patients deserve only the best@

Robert is now faced with what to do next.

Questions to discuss

1. Is there a problem? What is it?
2. What might be the causes of this type of behavior?
- 3.. What should Robert do next?
4. What will be different if the situation is resolved?
5. How will Robert know if there is improvement?
6. How long will it take to get fixed?
7. Can Harriet continue to work at Good Hands Hospital?



Harriet Handson

Types of Managed Care Organizations

Overview

There are several different formats that managed care can take. This chapter will examine those formats and develop a basis for later chapters that will focus on the successful interaction with Managed Care Organizations and preparing your department, practice and staff for managed care.

Preview of major topics

Conventional Health Insurance

Health Maintenance Organizations

Preferred Provider Organizations

Exclusive Provider Organizations

Point of Service Plans

Specialty Managed Care Organizations

Physician Hospital Organizations and Provider Service Organizations

Organizational Structures of Health Care Organizations

Managed Care Organization Structure

Hospital Structure

Hospital Medical Staff Structure

Medical Groups and Independent Practice Association Structure

Medicare

Medicare Part A Coverage

Medicare Part B Coverage

The Scope of Medicare Coverage

Medicare Program Financing, Beneficiary Liabilities and Vendor Payments

Medicare Claims Processing

Managed Care in Medicare and Medicaid

Peer Review Organizations

Administration of Medicare

Medicaid

Medicaid Basis of Eligibility and Maintenance Assistance Status

Scope of Medicaid Services

Amount and Duration of Medicaid Services

Payment for Medicaid Services

Federal Regulation of Governmental Managed Care Programs

Federal Regulation of non Governmental Managed Care Programs

State Regulation of Managed Care

Implications of Managed Care Type for Rehabilitation Providers

Summary

Case Study: The New Director

Conventional Health Insurance

Conventional health insurance plans are not a type of managed care, but will be defined here for comparison sake. Conventional health insurance plans are also known as indemnity, or fee-for-service, plans. People enrolled in them may receive care from any physician or hospital that they choose. Generally, they must pay for some initial amount of health care spending themselves (the deductible) and pay coinsurance on any spending beyond that amount. Providers are paid on a fee-for-service basis.

Health Maintenance Organizations

Enrollees in a Health Maintenance Organization generally must receive all of their care from the Health Maintenance Organization's physicians and from hospitals with which the HMO contracts; otherwise, the expense is not covered. The services that they receive from HMO physicians are typically covered in full, apart from a flat dollar copayment for an office visit. (Copayments may also be required for such items as prescription drugs.) Providers often bear some financial risk for the costs of the services they provide or order on behalf of their patients (although physicians in some types of Health Maintenance Organizations may receive a salary).

Health Maintenance Organizations (HMOs) function much like an insurance company. They offer policies, collect premiums and bear financial risk. So how are Health Maintenance Organizations different than regular insurance companies? Insurance companies are a third party to patients and providers. Health Maintenance Organizations are also the provider. Health Maintenance Organizations usually sub-contract out to provider organizations but also share financial risk with providers. Health Maintenance Organizations require care to be delivered only by Health Maintenance Organization providers, except in emergencies or under special benefit plans. Health Maintenance Organizations, as the full name implies, emphasize preventive care.

There are several common structure for HMOs. Among them are:

- § **Staff Model** -- Organization owns its clinics and employs its docs.
- § **Group Model** -- Contract with medical groups for services.
- § **IPA Model** -- Contract with an Independent Practice Association that in turn contracts with individual physicians.
- § **Direct Contract Model** -- Contracts directly with individual physicians.
- § **Mixed Model** -- Members get options ranging from staff to IPA models.

Preferred Provider Organizations

Enrollees in a Preferred Provider Organization may receive services from any provider they choose, but typically they face significantly lower deductibles and coinsurance rates if they use physicians and hospitals that are part of the Preferred Provider Organization's network. The Preferred Provider Organization pays providers in the network on a fee-for-service basis. Unlike conventional insurance plans, however, those fees are negotiated between providers and the plan.

Health Maintenance Organizations are much more regulated than Preferred Provider Organizations (PPOs), so the term HMO has a very defined meaning. The term Preferred Provider Organization, however can be used to describe several different things:

- § A plan of benefits that has a dual option: a higher preferred level when Preferred Provider Organization providers are used so that the patient bears the least financial responsibility when the Preferred Provider Organization providers are used, and a lower standard level so

- that the patient bears more financial risk and has more out of pocket expense when non-participating providers are used.
- § A provider organization that contracts with purchasers to be the “preferred” Preferred Provider Organization providers under their dual choice plan
 - § An administrative organization contracting with providers, and brokering these contracts with Preferred Provider Organization purchasers.

Exclusive Provider Organizations

Exclusive Provider Organizations (EPOs) look similar to Health Maintenance Organizations with members, but typically don't have the same levels of risk sharing with providers. EPOs do require members to use EPO providers. EPOs are not subject to the same regulations as Health Maintenance Organizations, so they often have some of the pre-existing condition exclusions and other limitations as traditional and PPO insurance.

Point-of-Service Plans

POS plans are also known as HMO/PPO hybrids or open-ended Health Maintenance Organizations. As with a Preferred Provider Organization, enrollees may choose to receive services from providers who are not members of the POS plan's network, as well as from those who are members. When enrollees use network providers, a POS plan functions much like a Health Maintenance Organization. When they use other providers, by contrast, those providers are typically paid on a fee-for-service basis and enrollees are responsible for deductibles and coinsurance.

Health Maintenance Organizations and EPOs sometimes offer point-of-service benefit plans, which provide benefits when non-participating providers are used. A point of service plan is a Health Maintenance Organization plan which allows the member to pay little or nothing if they stay within the established Health Maintenance Organization delivery system, but permits member to choose and receive services from an outside doctor, any time, if they are willing to pay higher copayments, deductibles and possibly monthly premiums. These are also called open-ended plans.

Specialty Managed Care Organizations

Specialty Managed Care Organizations include a variety of non-medical Health Maintenance Organizations and Preferred Provider Organizations: Dental (Dental HMOs are called Dental Maintenance Organizations: DMOs); Vision; Behavioral Health; and Chiropractic. The basic structures and concepts that apply to health Managed Care Organizations also apply to specialty Managed Care Organizations and their affiliated provider organizations

Specialty Managed Care Organizations are offered on a stand-alone basis (notably dental & vision), where the Managed Care Organization isn't tied to the health plan, as a supplemental rider sold with the health plan, and as a carve-out, providing benefits normally inside the health plan.

Physician Hospital Organizations and Provider Service Organizations

A PHO (Physician Hospital Organization) that has contracted to directly provide care to a purchasers,

without arranging the care through a Health Maintenance Organization or other type of health plan, is functioning as a Provider Service Organization (PSO). Medicare has begun contracting with a limited number of PSOs in selected areas. Self insured employers also entered into such arrangements. The ability for PSOs to directly capitate or provide other certain functions may depend upon the enabling regulations of the state that the PSO operates in. Many states are in various stages of recognition, and regulation of PSOs.

Organizational Structures of Health Care Organizations

Managed Care Organization Structure

Managed care organizations, like any large business organization, are structured to allow individual departments to perform specialized tasks. Some of the most common Managed Care Organization departments and their functions are:

- \$ **Medical:** handles the medical management functions.
- \$ **Claims:** receives and processes provider claims.
- \$ **Member Services:** handles member inquiries and problems.
- \$ **Marketing:** offers the plan to organizations and individuals.
- \$ **Eligibility:** processes member enrollment and premiums.
- \$ **Information Systems:** manages plan hardware and software.
- \$ **Finance:** financial and accounting support functions .
- \$ **Provider Relations:** performs contracting, credentialing and provider service functions.

Hospital Structure

Hospitals also are structured to allow individual departments to perform specialized tasks. The most common hospital functional categories are patient care services, ancillary services and support services.

Patient care services include the inpatient (overnight) nursing units such as the medical/surgical; ob; and intensive care units (ICU) and certain outpatient (same day) nursing units. Ancillary services include other clinical departments (including the rehabilitation therapies), diagnostic units such as laboratory, radiology, nuclear medicine, etc; certain freestanding programs like home health and plant operations such as engineering, housekeeping and food service. Support services include financial and information systems functions, admitting, medical records, medical staff relations, marketing and managed care contracting.

Hospital Medical Staff Structure

In a typical hospital, administration manages the facility and employs non-physician staff, but the medical staff (the doctors using the hospital) are fairly autonomous from hospital administration and regulate doctors and clinical policy. All doctors practicing at a hospital must be included in the medical staff and abide by the Medical Staff Bylaws. Physicians must apply for privileges to practice at a hospital. Those who use a hospital regularly have active privileges and sit on the self-elected physician committees that govern the medical staff. A major medical staff function is credentialing privileges.

Medical Groups and Independent Practice Association Structure

In these organizations, the amount of structure needed depends on how much risk the

organization bears and how many members they serve. If they are capitated, most of the departments found in a typical health plan have to be somewhat duplicated within the Independent Practice Association, except marketing (and provider relations if a medical group has no subcontracts). In addition, larger medical groups must add many clinical departments like hospitals do (nursing staff, ancillary departments, medical records and support departments.) When capitated, a key issue is eligibility. Most organizations serve multiple Managed Care Organizations, and reconciling eligibility from multiple sources is difficult. This can amount to a significant source of overhead expense to the Independent Practice Association.

Medicare

Title XVIII of the Social Security Act, entitled "Health Insurance for the Aged and Disabled," is commonly known as "Medicare." As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons to complement the retirement, survivors and disability insurance benefits under Title II of the Social Security Act. When first implemented in 1965, Medicare covered most persons age 65 and over. Since then, legislation has added other groups: starting in 1972, persons who are entitled to Social Security or Railroad Retirement disability benefits for 24 months or more, and persons with end-stage renal disease (ESRD) requiring continuing dialysis or kidney transplant are entitled to Medicare benefits; and starting in 1973, certain otherwise non-covered aged persons who elect to buy into Medicare. Medicare consists of two parts: hospital insurance (HI), also known as "Part A;" and supplementary medical insurance (SMI), also known as "Part B." Hospital Insurance (Part A) is generally provided automatically to persons age 65 and over who are entitled to Social Security or Railroad Retirement Board benefits. Similarly, individuals who have received such benefits based on their disability, for a period of at least 24 months, are also entitled to Part A benefits. In 1996, the Part A program provided protection against the costs of hospital and specific other medical care to about 38 million people (33 million aged and five million disabled enrollees). Approximately 22 percent of these individuals received services covered by Part A during the year. The Part A benefits totaled \$128.6 billion in 1996, -- an increase of 10.5 percent over the prior year, with an average expenditure per Part A enrollee of \$3,400, -- an increase of 9 percent over 1995.

Medicare Part A Coverage

Inpatient hospital care coverage includes costs of a semi-private room, meals, regular nursing services, operating and recovery room, intensive care, inpatient prescription drugs, laboratory tests, X-rays, therapy services and all other medically necessary services and supplies provided in the hospital. Skilled nursing facility (SNF) care is covered by Part A only if it follows within 30 days(usually) of a hospitalization of three or more days, and is certified as medically necessary. Covered services are similar to those for inpatient hospital, but also include rehabilitation services and appliances. The number of SNF days provided under Medicare is limited to 100 per benefit period (defined below), with a co-payment

required for days 21 through 100. Medicare Part A covers nursing facility care at an extended care facility only if the patient requires a skilled level of nursing care or a skilled level of rehabilitation services. Home Health Agency (HHA) care, including a home health aide, may be furnished by a home health agency in the residence of a home-bound beneficiary if intermittent or part-time skilled nursing, or rehabilitation care is necessary. There must be a plan of treatment and periodical review by a physician. Home health care under Part A has no time limitations, no co-payment, and no deductible. However, full-time nursing care, food, blood, and drugs are not provided as HHA services. Hospice care, is a service provided to those terminally ill persons with a life expectancy of six months or less who elect to forgo traditional medical treatment for the terminal illness and to receive only limited (hospice) care. Hospice care neither hastens death nor does it prolong life with extraordinary measures. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services and symptom management for a terminal illness. However, if a hospice patient requires treatment for a condition that is not related to the terminal illness, Medicare will pay for all covered services necessary for that condition. For the hospice program, the Medicare beneficiary pays no deductibles, but does pay a very small coinsurance amount for drugs and the cost of respite care.

A major aspect of Part A is the "benefit period" which starts when the beneficiary first enters a hospital and ends

when there has been a break of at least 60 consecutive days since inpatient hospital or skilled nursing care was provided. There is no limit to the number of benefit periods (calendar year, usually) covered by Part A during a beneficiary's lifetime; however, inpatient hospital care is normally limited to 90 days during a benefit period, and co-payment requirements (detailed later) apply for days 61 through 90. If a beneficiary exhausts the 90 days of inpatient hospital care available in a benefit period, he or she can elect to use days of Medicare coverage from a nonrenewable "lifetime reserve" of up to 60 (total) additional days of inpatient hospital care.

Medicare Part B Coverage

Supplementary Medical Insurance (Part B) benefits are available to: almost all resident citizens age 65 and over; certain aliens age 65 or over -- even to those who are not entitled (based on eligibility for Social Security or Railroad Retirement benefits) for Part A Medicare services; and disabled beneficiaries who are entitled to Medicare Part A. Part B coverage is optional, and requires payment of a monthly premium.

Almost all persons

entitled to Part A also choose to enroll in Part B. In 1996, the Part B program provided protection against the

costs of physician and other medical services to about 36 million people. Approximately 84 percent of these individuals received medical services covered by Part B during 1996, with total Part B benefits on their behalf amounting to \$68.6 billion.

Part B (SMI) is often thought of primarily as coverage for physician services (in both hospital and non-hospital

settings). However, Part B also covers certain other non-physician services, including: clinical laboratory tests,

durable medical equipment, most supplies, diagnostic tests, ambulance services, flu vaccinations, prescription drugs which cannot be self-administered, certain self-administered anticancer drugs, rehabilitation therapy services, certain other health services, and blood which was not supplied by Part A. The expenditures for institutional services in hospital outpatient departments, ambulatory surgical centers and

certain other centers are also covered. Home Health Agency services are covered under Part B if there is no Part A entitlement. All services must be medically necessary to be covered. Certain medical services and related care

are subject to special payment rules, including: deductibles (for blood); maximum approved amounts (for independently practicing, Medicare-approved physical therapists, occupational therapists or speech-language pathologists); or higher cost-sharing requirements (such as that for outpatient treatments for mental illness).

Non-covered services under Medicare include long term nursing care or custodial care, and certain other health

care needs -- such as dentures and dental care, eyeglasses, hearing aids, most prescription drugs, etc.

These are not a part of either the Part A or the Part B program unless they are a part of a special "managed care plan."

The Scope of Medicare Coverage

When Medicare began on July 1, 1966, there were 19.1 million persons enrolled in the program. By the end of 1966, 3.7 million persons had received at least some health care services covered by Medicare. In 1996, about 38 million persons were enrolled in one or both parts of the Medicare program. About 84 percent of all Medicare "enrollees" used some Part A and/or Part B service in 1996. As of January 1, 1997, more than 4.9 million Medicare beneficiaries were enrolled in a total of 336 managed care plans, accounting for 13 percent of the total Medicare population. That represents a 108 percent increase in managed care enrollment since 1993. In 1996, an average of 80,000 Medicare beneficiaries voluntarily enrolled in risk-bearing Health Maintenance Organizations each month. Medicare beneficiaries can enroll or disenroll in a managed care plan at any time and for any reason with only 30 days notice.

Managed care plans can serve Medicare beneficiaries through three types of contracts: risk, cost, and health care prepayment plans (HCPPs). All plans receive a monthly payment from the Medicare program. Risk plans are paid a per capita premium set at approximately 95 percent of the projected average expenses for fee-for-service beneficiaries in a given county. Risk plans assume full financial risk for all care provided to Medicare beneficiaries. Risk plans must provide all Medicare-covered services, and most plans offer additional services, such as prescription drugs and eyeglasses.

With the exception of emergency and out-of-area urgent care, members of risk plans must receive all of their care through the plan. However, as of January 1, 1996, risk plans can provide an out-of-network option that, subject to certain conditions, allows beneficiaries to go to providers who are not part of the plan. Since Jan. 1, 1993, enrollment in risk plans has grown more than 170 percent. Currently, 86 percent of the 18 million Medicare beneficiaries in managed care are in risk plans. As of January 1, 1997, risk plans made up 248 of the 350 managed care plans participating in Medicare. Cost plans are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget.

Cost plans must provide all Medicare-covered services, but do not provide the additional services that some risk plans offer. Beneficiaries can also obtain Medicare-covered services outside the plan without limitation. When a beneficiary goes outside the plan, Medicare pays its traditional share of those costs and the beneficiary pays Medicare's coinsurance and deductibles. Health Care Prepayment Plans (HCPPs) are paid in a similar manner as cost plans but only cover part of the Medicare benefit package. HCPPs do not cover Medicare Part A services (inpatient hospital care, skilled nursing, hospice, and some home health care) but some do arrange for services and may file Part A claims for their members.

Nationally, three-fourths of Medicare beneficiaries have a choice of at least one managed care plan while

more than half have a choice of two or more plans. Medicare managed care enrollment varies greatly depending on geographic location. The majority of beneficiaries enrolled in such plans live in California, Florida, Oregon, New York, Arizona, and Hawaii. HCFA recently launched the "Medicare Choices" demonstration project designed to allow beneficiaries to join a wider variety of managed care plans and to extend managed care options to rural areas. Enrollment is now underway in six participating plans. They include four provider sponsored networks (PSNs), a preferred provider organization (PPO), and a "triple option" hybrid that lets members see gatekeeper physicians, other plan providers without going through the gatekeeper, or providers outside the plan. An additional 13 demonstration plans are expected to begin enrollment during 1997. This "Choices" project is also testing new payment methods, such as partial capitation and adjustments based on the actual health needs of beneficiaries.

Medicare Program Financing, Beneficiary Liabilities, and Vendor Payments

All financial operations for Medicare are handled through two trust funds, one for Hospital Insurance and one for Supplementary Medical Insurance. These trust funds, with are special accounts in the U. S. Treasury, are credited with all income receipts and charged with all Medicare expenditures for benefits and administration costs. Assets not needed for the payment of costs are invested in special Treasury Securities. The following sections describe Medicare's financing provisions, beneficiary cost-sharing requirements, and the basis for determining Medicare reimbursements to health care providers. The Medicare program's expenses (for provided benefits and for administration) are paid for primarily from two separate trust funds. Part A revenues accrue mainly from a tax on individuals' employment earnings. Part B revenues come from the payment of premiums by or on behalf of individuals, plus significant contributions from the general revenue of the Federal government. Most services covered by Medicare also require some form of cost-sharing from beneficiaries.

Program Financing

Almost all employees and self-employed workers in the U.S. work in employment covered by the Part A program and pay taxes to support the cost of benefits for aged and disabled beneficiaries. For Part A, financing is primarily through a mandatory payroll deduction ("FICA tax") of 1.45 percent of earnings (paid by each employee and by the employer for each), as well as 2.90 percent for self-employed persons. For 1994 and later, this tax is paid on all covered wages and self-employment income without limit. (Prior to 1994, the tax applied only up to a specified maximum amount of earnings.) The Part A trust fund also receives income from: (i) a portion of the income taxes levied on Social Security benefits paid to high-income beneficiaries, (ii) premiums from certain persons who are not otherwise eligible and choose to enroll voluntarily, (iii) general funds reimbursements for the cost of certain other uninsured individuals, and (iv) interest earnings on the invested assets of the trust fund. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Income not needed to pay current benefits and related expense is invested in U.S. Treasury securities. The hospital insurance trust fund money is used only for the Part A program, and the Part B trust funds cannot be transferred for Part A use.

For Part B, financing is through: 1) premium payments (\$43.80 per month in 1997) which are usually deducted from the monthly Social Security benefit checks of those who are voluntarily enrolled in the Part B plan, and 2) through contributions from general revenue of the U.S. Treasury. Part B benefits may also be "bought" for persons by a third party directly paying the monthly premium on behalf of the enrollee. Beneficiary premiums are currently set at a level that covers 25 percent of the average cost for aged

beneficiaries. Except for a small amount of interest income, general revenues provide the balance of the financing for Part B.

Beneficiary Payment Liabilities

For Parts A and B, beneficiaries are responsible for charges not covered by the Medicare program, and for various cost-sharing aspects of both Part A and Part B. These liabilities may be paid: (1) by the Medicare beneficiary, (2) by a third party such as private "Medigap" insurance (secondary insurance) purchased by the Medicare beneficiary, or (3) by Medicaid, if the person is eligible. The term "Medigap" is used to mean private health insurance which, within limits, pays most of the health care service charges not covered by Parts A or B of Medicare. These policies, which must meet federally-imposed standards, are offered by Blue Cross (for Part A) and Blue Shield (for Part B), and various commercial health insurance companies.

For Part A, the beneficiary's payment share includes a one-time deductible amount at the beginning of each benefit period (\$760 in 1997). This covers the beneficiary's part of the first 60 days of each spell of inpatient hospital care. If continued inpatient care is needed beyond the 60 days, additional coinsurance payments (\$190 per day in 1997) are required through the 90th day of a benefit period. Medicare pays nothing after day 90, unless the beneficiary elects to use "lifetime reserve" days, for which a co-payment (\$380 per day in 1997) is required from the beneficiary.

For skilled nursing care covered under Part A, the first 20 days of SNF care are fully covered by Medicare. But for days 21 through 100, a co-payment (\$95 per day in 1997) is required from the beneficiary. After 100 days of SNF care per benefit period, Medicare pays nothing for SNF care. Home health care has no deductible or co-insurance payment by the beneficiary. In any Part A service, the beneficiary is responsible for fees to cover the first three pints or units of non-replaced blood per calendar year. The beneficiary has the option of paying the fee or of having the blood replaced.

There are no premiums for the Part A portion of Medicare for most people aged 65 and over. Eligibility for Part A is generally earned through the work experience of the beneficiary or that of a spouse. However, some persons

who are otherwise unqualified for Medicare may purchase Part A coverage if they also buy the Part B coverage. The cost is determined by a formula: if they have 30 to 39 quarters of coverage as defined by the Social Security Administration, the 1997 cost of Part A is reduced to \$187 per month; if not, the Part A cost is \$311 per month.

For Part B, the beneficiary's payment share includes: one annual deductible (1997 = \$100); the monthly premiums; the co-insurance payments for Part B services (usually 20 percent of the covered expenses); a deductible for blood; and payment for any services which are not covered by Medicare. These "cost-sharing" contributions are required of the beneficiaries for Part B services. For ESRD patients, Medicare Part B covers kidney dialysis and physician charges incurred by the patient and donor during the transplant and follow-up care. Regular Part B cost-sharing requirements also apply for ESRD services.

Vendor Payments

For Part A, prior to 1983, payment to vendors was made on a "reasonable cost" basis. Medicare payments for most inpatient hospital care are now paid under a plan known as the Prospective Payment System (PPS).

Under the PPS, a hospital is paid a predetermined amount, based upon the patient's diagnosis within a "diagnosis related group" (DRG), for providing whatever medical care is required during that person's inpatient hospital stay. The payment remains constant, therefore, in some cases the payment received is

less than the hospital's actual costs if the patient requires more service or a longer length of stay (LOS). In other cases it is more. The hospital absorbs the loss or makes a profit. Certain payment adjustments exist for extraordinarily costly cases. Payments for home health, for hospice and for skilled nursing care coverage continue to be paid under the reasonable cost methodology, with each service having some restrictions and limitations.

For Part B, prior to 1992, physicians were paid on the basis of "reasonable charge." This was initially defined as the lowest of (1) the physician's actual charge, (2) the physician's customary charge, or (3) the prevailing charge for similar services in that locality. Starting January, 1992, allowed charges were defined as the lesser of: the submitted charges, or a fee schedule based on a relative value scale (RVS). Durable medical equipment and clinical laboratory services are also based on a fee schedule. Outpatient services and HHAs are reimbursed on a reasonable cost basis.

If a doctor or supplier agrees to accept the Medicare approved rate as payment in full ("takes assignment"), then payments provided must be considered as payments in full for that service. No added payments (beyond the initial annual deductible and co-payments) may be sought from the beneficiary or insurer. If the provider does not take Medicare assignment, the beneficiary will be charged for the excess (which may be paid by Medigap insurance).

Limits now exist on the excess which providers can charge. However, since Medicare beneficiaries may select their doctors, they have the option to choose those who do take assignment.

Medicare Claims Processing

Medicare claims are processed by non-government organizations or agencies that contract to serve as the fiscal agent between providers and the Federal government to locally administer Medicare's Part A and Part B. These claims processors are known as "intermediaries" and "carriers."

Medicare "intermediaries" process Part A claims for institutional services, including inpatient hospital claims, skilled nursing facilities, home health agencies, and hospice services. They also process outpatient claims for Part B. Examples of intermediaries are the Blue Cross and Blue Shield Association (which utilize their plans in various States), and other commercial insurance companies.

Intermediaries' responsibilities include:

- \$ determining costs and reimbursement amounts;
- \$ maintaining records;
- \$ establishing controls;
- \$ safeguarding against fraud and abuse or excess use;
- \$ conducting reviews and audits;
- \$ making the payments to providers for services; and
- \$ assisting both providers and beneficiaries as needed.

Medicare "carriers" handle Part B claims for services by physicians and medical suppliers. Examples of carriers are the Blue Shield plans in a State and various commercial insurance companies.

Carriers' responsibilities include:

- \$ determining charges allowed by Medicare;
- \$ maintaining quality of performance records;
- \$ assisting in fraud and abuse investigations;
- \$ assisting both suppliers and beneficiaries as needed; and
- \$ making payments to physicians and suppliers for services which are covered under Part B.

Managed Care in Medicare and Medicaid

Since 1993, the number of Medicare and Medicaid beneficiaries enrolled in managed care plans has experienced unprecedented growth. The Health Care Financing Administration (HCFA), which administers these two programs, is now the largest purchaser of managed care in the country, accounting for about 18 million Americans. As a result, HCFA is taking new steps to protect beneficiaries in managed care. These steps include banning "gag clauses" on what physicians can say to patients about treatment options, requiring state-of-the-art member satisfaction surveys and measurement of health plan performance, and limiting financial incentives for physicians so that efforts to control costs do not curtail needed care. The Clinton Administration has worked in close partnership with the states to provide maximum flexibility through the waiver of Federal rules to expand the availability of managed care plans to Medicaid beneficiaries. The Administration has also worked to expand choices for Medicare beneficiaries and to ensure that all beneficiaries enrolled in managed care receive quality care.

As part of The Balance Budget Act of 1997, there is further expansion of the availability of managed care to Medicare and Medicaid beneficiaries through the Medicare +Choice program (see Chapter 7 - The Balance Budget Act of 1997).

Peer Review Organizations

Peer Review Organizations (PROs) are groups of practicing health care professionals who are paid by the Federal government to do the general overview of the care provided to Medicare beneficiaries in each State, and improve quality of services. PROs act to educate and assist in the promotion of effective, efficient and economical delivery of health care services to the Medicare population they serve.

Administration of Medicare

The Department of Health and Human Services (HHS) has the overall responsibility for administration of the Medicare program, with the assistance of the Social Security Administration (SSA). The Health Care Financing Administration (HCFA) is a component of DHHS. HCFA has primary responsibility for Medicare, including:

- \$ formulation of policy and guidelines; contract over-sight and operation;
- \$ maintenance and review of utilization records;
- \$ and general financing of Medicare.

SSA is responsible for the initial determination of an individual's Medicare entitlement, and has the overall responsibility for maintaining the Medicare master beneficiary record.

A Board of Trustees, which is composed of two appointed members of the public and four ex-officio members, holds the trust funds for both Part A and Part B. The Secretary of the Department of Treasury is the managing trustee. The Board of Trustees reports the status and operation of the Medicare trust funds to Congress on or about the first day of April each year.

State agencies (usually State Health Departments under agreements with HCFA) assist by helping DHHS to identify, survey, and inspect provider and supplier facilities or institutions wishing to participate in the Medicare program. In consultation with HCFA, they certify those that are qualified. The State agency also assists providers as a consultant, and coordinates the various State programs to assure effective and economical endeavors.

Medicaid

Title XIX of the Social Security Act is a Federal-State matching entitlement program that pays for medical assistance for certain vulnerable and needy individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the Federal and State* governments to assist States furnishing medical assistance to eligible needy persons. Medicaid is the largest program funding medical and health-related services for America's poorest people. (For our purposes, "State" includes the D.C. and Territories). Within broad national guidelines established by federal statutes, regulations and policies, each of the States:

- § establishes its own eligibility standards;
- § determines the type, amount, duration, and scope of services;
- § sets the rate of payment for services; and
- § administers its own program.

Medicaid policies for eligibility and services are complex, and vary considerably even among similar-sized and/or adjacent States. Thus, a person who is eligible for Medicaid in one State might not be eligible in another State; and the services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State. In addition, Medicaid eligibility and/or services within a State can change during the year.

Medicaid Basis of Eligibility and Maintenance Assistance Status

In order to receive Medicaid, certain eligibility criteria must be met. Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the Federal statute, Medicaid does not provide health care services even for very poor persons unless they are in one of the groups designated below. And low income is only one test for Medicaid eligibility for those within these groups; their resources also are tested against threshold levels (as determined by each State within Federal guidelines).

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. However, to be eligible for Federal funds, States are required to provide Medicaid coverage for certain individuals who receive Federally assisted income-maintenance payments, as well as for related groups not receiving cash payments.

The Medicaid "categorically needy" eligibility groups are:

- § Individuals are generally eligible for Medicaid if they meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their State on July 16, 1996;
- § Children under age six whose family income is at or below 133% of the Federal poverty level (FPL);
- § Pregnant women whose family income is below 133% of the Federal poverty level (services to the women are limited to: pregnancy, complications of pregnancy, delivery and postpartum care);
- § Certain Medicare beneficiaries;
- § Supplemental Security Income (SSI) recipients in most States (some States use more restrictive Medicaid eligibility requirements that pre-date SSI);
- § Recipients of adoption assistance and foster care who are under Title IV-E of the Social Security Act;
- § Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time); and

§ All children born after September 30, 1983 who are under age 19, in families with incomes at or below the Federal poverty level. (This phases in coverage, so that by the year 2002, all poor children under age 19 will be covered).

States also have the option of providing Medicaid coverage for other "categorically related" groups. These optional groups share the characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined. The broadest optional groups for which States will receive Federal matching funds for coverage under the Medicaid program include:

- § Infants up to age one and pregnant women not covered under the mandatory rules whose family income is no more than 185% of the Federal poverty level (the percentage amount is set by each State);
- § Children under age 21 who meet what were the AFDC income and resources requirements in effect in their State on July 16, 1996, (even though they do not meet the mandatory eligibility requirements);
- § Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services waivers;
- § Institutionalized individuals eligible under a special income level (the amount is set by each State -- up to 300% of the SSI federal benefits rate);
- § Recipients of State supplementary income payments;
- § TB-infected persons who would be financially eligible for Medicaid at the SSI income level if they were within a Medicaid-covered category (however, eligibility is only for TB-related ambulatory services and for TB drugs);
- § Certain aged, blind or disabled adults who have incomes above those requiring mandatory coverage, but below the Federal poverty level; and
- § "Medically needy" persons.

The Medically Needy (MN) program allows States the option to extend Medicaid eligibility to additional qualified persons. These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their State. MN income levels are higher than the regular Medicaid eligibility income levels. Persons may qualify immediately, or may incur medical expenses that cause them to be at or below their State's MN income level.

The medically needy Medicaid program does not have to be as extensive as the categorically needy program, and may be quite restrictive in rules as to who is covered and/or as to what services are offered. Federal matching monies are available for MN programs. However, if a State elects to have any MN program, there are federal requirements that certain groups and certain services must be included. Children under age 19 and pregnant women who are medically needy must be covered; and prenatal and delivery care for pregnant women, and ambulatory care for children must be provided. A State may elect to provide MN eligibility to certain additional groups, and may elect to provide certain additional services within its MN program. In 1996, forty-two States elected to have an MN program, and provided at least some MN services for at least some MN recipients. The remaining States utilize the "special income level" option (above) to assist other low income institutionalized aged persons.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193) – known as the "welfare reform" bill -- made restrictive changes regarding eligibility for Supplemental Security Income (SSI) coverage that will have an impact on the Medicaid program. Some persons who would earlier have been eligible for Medicaid because of entitlement to the SSI program will not be covered now because of these changes. The new law may be significant for certain aliens' Medicaid

coverage. For legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996 whose coverage is not mandatory (for example, they do not have 40 qualifying quarters of Social Security coverage), Medicaid is not available to them for five years. Medicaid for such aliens entering before that date is a State option, as is coverage after the five year ban, except for emergency services. Many aliens may be losing SSI benefits. These persons can continue on Medicaid only if they can be covered for Medicaid under some other eligibility status; otherwise they are eligible only for emergency care. Although a number of disabled children will lose SSI as a result of changes to the Public Law 104-193, a great majority of disabled children currently covered by Medicaid will maintain eligibility through other Medicaid eligibility criteria.

Other changes in the Public Law 104-193 regarding cash payments repealed the open-ended Federal entitlement program known as Aid to Families with Dependent Children (AFDC), and replaced it with the program known as Temporary Assistance for Needy Families (TANF), which will provide grants to States to be spent on time-limited cash assistance. Temporary Assistance for Needy Families limits a family's lifetime cash welfare benefits to five years. However, changes in Medicaid eligibility are not expected to be significant. Under welfare reform, persons who would have been eligible for AFDC (that is, they meet the requirements that were in effect on July 16, 1996,) generally will still be eligible for Medicaid. Although most persons covered by TANF will receive Medicaid, the law does not so require.

Once eligibility for Medicaid is determined, coverage is retroactive to the third month prior to application if the person would have been eligible for Medicaid had he applied in that period. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group. In addition to the Medicaid program, most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal funds are not provided for these State-only programs.

Scope of Medicaid Services

Title XIX of the Social Security Act requires that a State Medicaid program must offer medical assistance for certain basic services to most categorically needy populations. These services generally include:

- \$ inpatient hospital services;
- \$ outpatient hospital services;
- \$ prenatal care;
- \$ vaccines for children;
- \$ physician services;
- \$ nursing facility services for persons aged 21 or older;
- \$ family planning services and supplies;
- \$ rural health clinic services;
- \$ home health care for persons eligible for skilled-nursing services;
- \$ laboratory and x-ray services;
- \$ pediatric and family nurse practitioner services;
- \$ nurse-midwife services;
- \$ Federally-qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings; and

States may also receive Federal matching funds for providing certain optional services. The most common of the 34 currently-approved optional Medicaid services include:

- \$ diagnostic services;
- \$ clinic services;
- \$ intermediate care facilities for the mentally retarded (ICFs/MR);
- \$ prescribed drugs and prosthetic devices;
- \$ optometrist services and eyeglasses;
- \$ nursing facility services for children under age 21;
- \$ transportation services;
- \$ rehabilitation and physical therapy services; and
- \$ home and community-based care to certain persons with chronic impairments (this one is an option only with an approved waiver).

Amount and Duration of Medicaid Services

Within broad Federal guidelines, States determine the amount and duration of services offered under their Medicaid programs. They may limit, for example, the number of days of hospital care or the number of physician visits covered. However, some restrictions apply: Limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits. Limits on required (non-optional) benefits may not discriminate among beneficiaries based on medical diagnosis or condition.

In general, States are required to provide Medicaid coverage for comparable amounts, duration and scope of services to all categorically-needy and categorically-related eligible persons. There are two important exceptions: 1) Medically necessary health care services identified under the Early Periodic Screening, Diagnosis & Treatment (EPSDT) program for eligible children which are within the scope of mandatory or optional services under federal law, must be covered even if those services are not included as part of the covered services in that State's Plan (i.e., only these specific children might receive that specific service); and 2) States may request "waivers" to pay for otherwise-uncovered home and community-based services (HCBS) for Medicaid-eligible persons who might otherwise be institutionalized (i.e., only persons so designated might receive Home and Community Based Services, HCBS). States have few limitations on the services which may be covered under such waivers as long as the services are cost effective (except that, other than as a part of respite care, they may not provide room and board for such recipients). With certain exceptions, a State's Medicaid Plan must allow recipients to have freedom of choice among participating providers of health care.

Payment for Medicaid Services

Medicaid operates as a vendor payment program, with States paying providers directly. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). Within Federally-imposed upper limits and specific restrictions, each State generally has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid recipients and/or to other low-income persons under what is known as the "disproportionate share hospital" (DSH) adjustment. Under legislation passed in 1991 and 1993, DSH payments are now limited.

States may impose nominal deductibles, coinsurance or co-payments on some Medicaid recipients for certain services. However, certain Medicaid recipients must be excluded from cost sharing: pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to institutional care, and categorically needy recipients enrolled in Health Maintenance Organizations. In addition, emergency services and family planning services must be exempt from co-payments for all recipients.

The Federal government pays a proportion of the medical assistance expenditures under each State's Medicaid program, known as the Federal Medical Assistance Percentage (FMAP). The Federal Medical Assistance Percentage is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capital income level are reimbursed a smaller share of their costs. By law, the Federal Medical Assistance Percentage cannot be lower than 50 percent nor higher than 83 percent. In 1997, the Federal Medical Assistance Percentages vary from 50 percent (to 13 States and D.C.) to 77.2 percent (to Mississippi), with the average Federal share among all States being 57.0 percent. The Federal government also reimburses States for 100% of the cost of services provided through facilities of the Indian Health Service. The Federal government also shares in each State's expenditures for the administration of the Medicaid program. Most administrative costs are matched at 50 percent for all States, with higher rates for certain activities such as development of mechanized claims processing systems.

The Medicaid statute does provide for higher matching rates for certain functions and activities. Federal payments to States for medical assistance have no set limit (cap); rather, the Federal government matches (at Federal Medical Assistance Percentage rates) State expenditures for the mandatory services plus the optional services that the individual State decides to cover for eligible recipients, and matches (at the appropriate administrative rate) necessary and proper administrative costs.

Federal Regulation of Governmental Managed Care Programs

Federal law governs programs like Medicare, Champus (Civilian Health and Medical Program for the Uniformed Services), and how the states administer Medicaid. These programs are also used to set policy on how providers practice; i.e., payments or participation may be denied or other penalties imposed if providers violate these regulations. Federal law also governs purchasers who qualify to self-insure. ERISA (Employment Retirement Income Security Act) regulations govern self-insured groups, and exempts them from applicable state laws. This way a group operating in many states keeps its plan the same in every state.

Federal Regulation of Non Governmental Managed Care Programs

States govern the operation of Managed Care Organizations. But federal law (Health Maintenance Organization Act of 1973) also sets numerous ground rules and standards for the operation of Health Maintenance Organizations, and allows for HMOs to go through a Federal Qualification process, where the Health Maintenance Organization is certified to meet federal standards.

The federal government also sets policy regarding Managed Care Organizations through Medicare, Medicaid and Champus regulations, setting numerous requirements and standards for applicable Managed Care Organizations to be offered under these programs. Medicare Risk Health Maintenance Organization regulations for example, have a large impact on the plans contracting with Medicare to serve enrolled members.

State Regulation of Managed Care

States govern the operations of insurance companies and Managed Care Organizations. States govern the licensure and practice of health care professionals. While there is much in common in these state laws, there are also numerous differences from state to state. States require insurance companies and Health Maintenance Organizations to: obtain and maintain a license to operate; have certain levels of financial reserves; submit periodic financial and operating reports; get state approval to make certain changes in benefits, premiums, or service areas; and submit to various audits and comply with requested corrective actions. Provider organizations are mostly unregulated under insurance laws.

Other Legal Issues

Some areas of major activity and concern include:

- § Managed Care Organization and provider organization liability for medical management decisions, credentialing actions, and benefit coverage decisions.
- § Antitrust issues as Managed Care Organizations merge, provider organizations merge, and individual physicians integrate more.
- § Allowed business practices as Medicare and others sanction providers for using prohibited business methods, particularly relating to hospital relationships with doctors, and MD referrals to facilities from which they financially benefit.

Implications of Managed Care Organization Type for Rehabilitation Service Providers

The relative penetration of the various types of managed care varies throughout the country. It is usually dangerous to generalize. In the area of managed care, over generalization can be particularly dangerous. As a case in point, there is currently a very high managed care penetration in the State of Oregon. Compared to Massachusetts, there is a difference of 45% (OR) to 30% (MA) or almost half again as much. However, on closer examination, there is a much higher HMO penetration in Massachusetts than

in Oregon. The impact of managed care on rehabilitation services has been much more severe in Massachusetts than in Oregon, in spite of the higher overall MCO penetration. Clearly, the type of MCO is very important to the rehabilitation manager and the preferred strategies for managed care success. Much more important than overall managed care penetration in your market is the financial relationships that exist between your practice and the MCOs. The method of reimbursement used to determine payment will be critical. Even in some markets where HMO penetration is quite high, if there is predominantly a discounted fee for service model of rehabilitation reimbursement, and little risk sharing, the impact of managed care may be relatively less than in those markets where risk sharing is the standard reimbursement model.

Chapter 4 will further examine not just the type of MCO, but rather, the financial relationship between rehabilitation providers and the managed care organization.

Summary

This chapter has reviewed the different types and structures of managed care organization that are commonly encountered in the management of rehabilitation programs and practices. By understanding the typical structures of managed care organization, the rehabilitation manager should be better prepared to understand the financial implications and incentives of the various forms of managed care.

Case Study

The New Director

The Scenario

Mr. Fred Dwyer has been director of PT and Rehabilitation at St. Isaac Hospital for six weeks. He has 10 years experience as a manager and 15 as a PT. Prior to Fred accepting this position, it had been vacant for 12 months after the previous director was terminated. Fred is not completely aware of all the circumstances leading to the previous director's dismissal.

St. Isaac Hospital is a 250 bed community hospital in suburban Chicago. Physical therapists at St. Isaac are involved in treating patients on the medical/surgical units, the 20 bed adult rehab unit, and in the outpatient department.

Suburban Chicago has been a very difficult recruitment environment for quite some time. There are many PT jobs available and not enough PTs to fill them. Currently St. Isaac has 8 full time PTs but 4 additional positions are open and have been for over 8 months.

Fred reports to Jan Mitchell, Vice President of Professional Services who hired Fred. Jan believes that PT, like all of the services under her should be productive, growing and fully staffed. Jan often considers PTs as technicians in the same category as housekeeping and maintenance personnel. Fred has repeatedly explained that PTs are much more like medical staff members in their autonomy and ability to produce revenue and positive patient relationships for the hospital. Fred is sure that Jan is unswayed by his arguments.

Upon his arrival, Fred decided to be sure he knew what was going on in the department before he changed anything. Fred found no managerial hierarchy within the department. Each staff member reported directly to him. There were no differentiated duties or expertise recognized within the department. Volume within the department is increasing steadily but so is staff frustration, complaints and use of sick time. Staff are currently treating 12-15 patients each day, including at least two rehab patients. Fred is also seeing a full load of patients to help keep up. Staff morale is low and there are rumors of a possible mass staff exodus if the new director "did not fix things quickly".

The Crisis

This morning, after 6 weeks on the job, Fred was called to Jan's office because members of the staff had written a letter to Administration to complain. During the brief meeting Jan would not show Fred the letter, but told Fred that it came from most but not all of his staff. The complaints that Jan related to Fred include the following (in the order that Jan mentioned them):

The work load is too high for quality treatment.

Things are no better with the new director than they were when the position was open.

There is no program development occurring.

Morale is terrible.

The director is not available to staff because he spends too much time on unimportant "political" issues.

No new staff has been hired to help.

When problems are brought to the new director, he "doesn't solve them for us" but says "let's work this through together". Then he expects the staff to solve the problem themselves.

No one knows how they are performing. No one says thanks.

Rumors are out of control.

If things don't get better, a large percentage of the staff will leave very soon.

Jan told Fred to "fix this now. I don't want any more of this kind of letter."

When Fred asked for suggestions, Jan suggested that that was his job, but to keep her apprized in writing.

Fred is now sitting in his office reviewing the events of the past six weeks and his possible actions.

Questions Fred is asking himself.

1. Is the situation resolvable?

2. Is this unexpected after 6 weeks on the job?

3. What symptoms are present?

4. What are the real problems here?

5. What actions should Fred take with the Staff?

6. What actions should Fred take with Jan?

7. What actions should Fred take with the department as a whole?

8. Should Fred be treating a full case load at this point? If not, how much time should he devote to patient care versus managing the department? Will staff lose even more respect for him if he doesn't help with patients?

9. What will be different in 6 months if Fred is successful in turning things around?

Reimbursement Methodologies in Physical Rehabilitation

Overview

This chapter will address the many different ways in rehabilitation providers are paid for the services we provide. The first part of the chapter will describe these methodologies in general terms as they affect all of health care. The second part of the chapter will examine each of the most common rehabilitation venues and describe how each of these practice settings is currently reimbursed. When the Balanced Budget Act of 1997 was passed, significant changes in reimbursement for Medicare and Medicaid were mandated. Changes affecting reimbursement for rehabilitation providers will be addressed in Chapter 7 - The Balanced Budget Act of 1997.

Preview of Major Topics

Mechanisms of Reimbursement

Fee For Service

Fee Schedule

Out of Pocket

Cost Reimbursement

Cost reports

Tax Equity and Fiscal Responsibility Act (TEFRA)

Prospective Payment

Diagnosis Related Groupings (DRG)

Case Rate (Case Capitation)

Capitation

Full Risk Sharing

Who are the Players?

The Transactions

HMO-Hospital Transactions

PPO-Hospital Transactions

IPA-Hospital Transactions

HMO-IPA-PHO Transactions

Risk as a currency

Therapy Venues and Reimbursement Methodology

Changing nature of reimbursement

Reference to Futures and The Balanced Budget Act of 1997 Section

Venues and Practice Settings for Rehabilitation Providers

Acute inpatient care

Hospital-based ambulatory care

Private Practice ambulatory care

Rehabilitation agency

Comprehensive Outpatient Rehabilitation Facility (CORF)

Community home care agency

Inpatient Medical Rehabilitation Programs

Skilled Nursing Facility (SNF)

Sub Acute Rehabilitation

Mechanisms of Reimbursement

Traditional indemnity, managed indemnity, Preferred Provider Organization (PPO), Point-of Service (POS) plan, and staff-model, Independent Practice Association (IPA) model, and individual provider-model Health Maintenance Organizations (HMO), are all insurance products offered or administered by a host of payors including employers, trusts, insurance companies, Health Maintenance Organizations, and Third Party Administrators (TPAs). At the same time, providers are being approached by these organizations wanting to contract for their multiple products.

Fee For Service

A fee for service (FFS) plan is a health care plan in which patients have the option of consulting any health care provider subject to reasonable requirements such as utilization review and prior approval of certain services but does not include a requirement to seek approval through a gatekeeper. FFS is a system of payment for health care whereby a fee is rendered for each service delivered. This traditional method contrasts with that used in the prepaid sector where services are covered by a fixed payment made in advance that is independent of the number of services rendered.

Under a fee-for-service system, the provider delivers, bills and is paid for each discrete increment of service or product provided to a patient. Fees might be discounted, but payment is calculated for each increment billed and combined to create a total billed amount. A single visit might result in several billed charges.

Historically, the most prevalent method of fee determination has been the usual, customary, or reasonable (UCR) fee. This is often a poorly defined rate that varies geographically. Recently, the use of a relative value scale (RVS) has gained popularity in fee for service plans. In the RVS system, each procedure has a relative value associated with it. The health plan pays on the basis of a monetary multiplier for the RVS value. Especially popular in rehabilitation services has been the resource based relative value scale (RBRVS) used by HCFA for the Medicare program. With changes in Medicare due to the Balanced Budget Act of 1997, RBRVS is likely to become the dominant reimbursement methodology in fee for service programs.

Because the inherent financial incentive in a FFS system is to reward higher intensity and frequency of care with higher reimbursement, FFS are often criticized for their potential for abuse and overutilization. Much of the cost containment efforts of managed care organizations has been directed at reducing the risk of overutilization in FFS reimbursement models. However, FFS reimbursement, in any of a variety of formats, remains prevalent in many plans and in a wide variety of geographic locations in the US. FFS is often the reimbursement mechanism in PPO - rehabilitation provider relationships. Even in many HMO plans, smaller volume providers are typically involved in some sort of FFS system.

Fee Schedule

A fee schedule is the document, under a FFS arrangement, that outlines all fee maximums that the participating provider will be paid by the payer within the term of the contract. It is, simply, a listing of charges of established benefits for specified procedures. It is, in essence, a menu - similar to what you would find in a restaurant. The primary difference is that the fees on the fee schedule are, technically, negotiated between the payer and the rehabilitation practice. Often the level of this negotiation is trivial, such as a State Bureau of Workers= Compensation posting their fee schedule and then requiring acceptance of it as a condition of participation. Technically, this is a negotiated schedule because the provider could choose to not participate. In reality, fee schedules are often, but clearly not always, imposed upon providers.

Many PPOs and HMOs use fee schedules as a mechanism to implement FFS arrangements with providers as explained above.

Within any fee schedule, there will be relatively well reimbursed and poorly reimbursed items.

Understanding the individual profit margins for specific procedures on the schedule is a common strategy for providers who are trying to maximize reimbursement. Taken to the extreme, this strategy can easily cross the line of conflict of interest for providers, such as rehabilitation professionals, who are actively involved in treatment intensity, frequency and type decision with and for patients.

It is also critical for the provider to clearly establish which procedures will be included on the fee schedule.

If a given procedure is not included in the fee schedule, it is often considered to be non-reimbursable. Problems will arise if procedures are omitted by oversight instead of intention.

Out of Pocket Payment

An additional option in a FFS is for the patient to pay for services out of pocket. This model of payment parallels that seen outside of health care, such as retail goods and services. In this model, the patient may choose to pay for services not covered by their insurance program or for services beyond the intensity or duration provided as benefit of their insurance program. Patients who are uninsured have no other recourse than to pay for services out of pocket. Unfortunately for the provider, out of pocket payment or private pay is often synonymous with no payment or bad debt.

A growing number of rehabilitation providers are focusing their practice on services or patients that fall outside the traditional insurance coverage guidelines. Although this market is small at present, it has become very attractive to practices who provide rehabilitation services to affluent populations. An advantage of this arrangement is that payment is often made prior to the service delivery so that there is not a prolonged collections period with its concomitant expenses and eventual revenue reductions due to write offs of non-collected fees.

Cost Reimbursement

In stark contrast to fee for service, where additional services provided and charges billed usually represents additional reimbursement, is the cost reimbursement system. In cost based reimbursement, the provider of services is paid the lesser of charges or full allowable cost plus an additional amount to cover the depreciation of facilities and capital equipment. Allowable costs are defined by the payer but, are generally limited to costs which can be shown to contribute directly to patient care.

Cost reimbursement was intended to directly address some of the incentives inherent in FFS that encouraged overutilization. Cost reimbursement is not based on charges generated, but rather on the cost to provide the service. Although some of the incentive toward overutilization of services was eliminated in cost reimbursement systems, there remain very strong incentives to keep reported costs artificially high so that maximal reimbursement is received.

In order to responsibly determine an appropriate level of reimbursement, extensive cost reports are usually required in cost reimbursement arrangements. The preparation of cost reports can represent a significant administrative task for some practices. The services of a financial professional skilled and familiar with the reporting format and requirements are required to successfully participate in a cost reimbursed program. This can be expensive and often establishes a barrier to smaller volume practice who may chose to forgo participation in the program because of the paperwork and overhead involved. Realistically, a fairly significant patient volume is needed to justify the additional cost and bother of cost reporting.

PPS Exempt Rehabilitation Units and Hospitals

One variation of cost reimbursement is found in prospective payment system exempt rehabilitation units and hospitals. (Psychiatric and units and hospitals and Pediatric hospitals may also be exempt from PPS if all criteria are met.) These inpatient rehabilitation programs were excluded from the acute care hospital prospective payment system established by the Tax Equity and Fiscal Responsibility Act (TEFRA) in 1983.

Inpatient rehabilitation programs continued to be reimbursed under a cost reimbursement model up to a cap that was established by close measurement of program costs during a base year of the program. For programs that were in existence prior to TEFRA 1983, the average costs of operation in previous years was used to establish this reimbursement ceiling, commonly referred to as a TEFRA cap. For programs that were initiated after the onset of the acute care PPS, the first year of operation was used as a cost-basing year.

Once the cost cap is established for acute inpatient rehabilitation programs, a typical cost reimbursement model is used except that there are financial incentives available to programs whose costs are below the cost cap established in their cost basing year. There are also financial disincentives for programs who exceed the cost cap.

Because each individual program has unique rates and caps, there is a wide variation in profitability for inpatient rehabilitation programs. There has also been significant discussions in the industry on methods to assure an adequately high TEFRA cap. Like FFS, cost reimbursement has been ineffective at containing health care cost in general, and rehabilitation cost and utilization specifically.

Prospective Payment

Prospective Payment Systems (PPS) have been developed to address the inadequacies of FFS and cost reimbursement methodologies at controlling health care costs and discouraging overutilization. In prospective payment, there is a predetermined payment for health care services that are to be provided according to contractual rates and terms regardless of the actual experience or costs incurred. In a PPS model, the provider, for the first time in any of the reimbursement models presented so far, assumes some of the financial risk for the care provided. If the provider can provide care more efficiently than anticipated, there is likely to be additional financial reward in the form of profit. If the provider is unable to deliver the health care services at a cost less than the predetermined payment level, there will be a financial loss by the provider. PPS provides an incentive for efficient care. Unfortunately, PPS can also provide an incentive for underutilization of needed services in some cases. Potentially, underutilization of care represents as much, or even more concern as overutilization.

There are a wide variety of models for PPS. As previously noted in Chapter 2, different models of reimbursement, especially different models of PPS, carry different levels of financial risk. The following chart represents these differences in financial risk by payment type. In each progressive step, financial risk is transferred from the payer, or insurer, to the provider, or practice.

Note that the payment methodologies represented on the chart as % of Charge and Per CPT are what we described above as fee for service. What is on the chart as Per CPT refers to being reimbursed according to a fee schedule based on the Common Procedural Terminology (CPT) coding system. In these two forms of reimbursement, the only financial risk can be quantified prior to delivery of the care. That risk is that the payment rate for each service will not exceed the cost to deliver the service. In reality, this is usually a very small risk for the provider. Per Visit is a very moderate form of prospective payment where the provider is reimbursed at a predetermined rate per patient visit, regardless of the intensity or

type of services provided during that visit. In this case, the provider is at some risk that the length of the visit or costs associated with delivering the care during that visit will exceed the predetermined visit rate. This risk is considerably higher for the provider than that in either of the first two reimbursement mechanisms.

The next reimbursement mechanism is Per Case in which the provider is reimbursed a predetermined rate for the entire episode of care for a given patient. The additional risk here is that the patient may

progress more slowly or have need for a longer duration of care. The previously mentioned risks are also present in this type of reimbursement method. Per case reimbursement is also often called case capitation. The prospective payment systems used by Medicare for acute hospitalization and commonly referred to as DRGs (diagnosis related groupings) is a form of per visit pricing or case capitation. The reimbursement rate per case is determined in DRGs by the primary diagnosis or problem with which the patient presents.

The final reimbursement method list on the chart below is capitation. In capitation, a predetermined amount is paid to a provider to care for a defined population, whether or not they ever become patients. The risk is highest in this model for the provider because the demand for services, or utilization rate, can change due to circumstances outside the control of the provider.

Let's now turn our attention to the parties who enter into the types of reimbursement relationships that we've described above.

Who Are the Players?

In managed care, on the payer side, there are three groups: Health Maintenance Organizations (including Point of Service plans or POS), Preferred Provider Organizations (generally including self-funded employers), and Independent Practice Associations (including Physician Hospital Organizations and large multispecialty groups). These payers have varying degrees of financial risk for health care costs for a group of enrollees, and are seeking to minimize those costs. This can be done either by passing on a portion of their risk to the provider, or by taking the risk but attempting to limit the amount of services used and the prices paid, and thus the cost. An example is a Health Maintenance Organization contracting for services to an Independent Practice Association through a capitation agreement, after which the Independent Practice Association attempts to negotiate favorable rates with its individual Primary Care Physician and specialist members. Here, the Health Maintenance Organization has effectively passed much of its risk to the Independent Practice Association, while the IPA has minimized its price risk through contracting. The IPA will attempt to manage its utilization risk through a variety of programs including utilization management, referral management and formal risk management programs.

On the provider side, there are also three basic groups: hospitals, Independent Practice Associations, and individual practitioners (including ancillary service companies, such as rehabilitation providers). These groups may be willing to contract with payors at discounted rates to obtain a flow of patients they would not otherwise receive. There may be little if any motivation for you to contract with a payer at discounted rates if the payer is unwilling or unable to "steer" patients to your practice through financial or other incentives. The concept of patient steerage is very important in situations where discounted fees are requested in return for increased patient volume. If there is not an increase in patient volume because patient steerage is inadequate, the discounted fees are essentially a gift to the payer. This logic holds not only for traditional indemnity payors, but also for Preferred Provider Organizations, employers, and workers' compensation firms that do not offer their members an incentive for using an in-network provider. Even in state where direct access of patients to rehabilitation providers is allowed by law without physician referral, reimbursement policy often precludes this functionally. That is without a physician referral, frequently the third party payer will not pay for rehabilitation services even in direct access states.

The Transactions

We will review the following potential payer-provider relationships:

- \$ Health Maintenance Organization/Hospital
- \$ Preferred Provider Organization/Hospital
- \$ Independent Practice Association/Physician Hospital Organization
- \$ Independent Practice Association/Physician Hospital Organization/Hospital
- \$ Preferred Provider Organization/Independent Practice Association/Hospital
- \$ Health Maintenance Organization/Independent Practice Association/Individual Practitioner

Health Maintenance Organization-Hospital Transactions:

In these agreements, the Health Maintenance Organization is seeking an aggressive contracted rate (either per diem or a substantial percentage discount). In return, the Health Maintenance Organization is offering aggressive patient steerage by limiting member benefits for out-of-network utilization. This can be a relatively equal exchange if the Health Maintenance Organization has significant membership and a limited network. In this situation, providers may find this arrangement to be very attractive. If however, the Health Maintenance Organization has a small membership, or is including every hospital in a market, then aggressive patient steerage does not really exist. Hospitals should offer per diems and discounts relative to the volume the Health Maintenance Organization brings in the door. It is not the hospital's responsibility to make a start-up or small Health Maintenance Organization price competitive for employers. As long as a hospital is a strong market presence in its service area, a Health Maintenance Organization will need that hospital in its provider network to attract employers and enrollees. For POS products, a hospital should request higher reimbursement for three reasons. First, the patient steerage is not as strong because of the out-of-network benefit. Second, the Health Maintenance Organization receives a higher premium for the POS product, and thus can afford to pay more. Finally, from an economic theory perspective, the patient has shown a willingness to pay extra for choice, and that premium should go to the organization which has created the demand.

Preferred Provider Organization-Hospital Transactions:

In these agreements, a Preferred Provider Organization is typically seeking a 15%-30% discount from charges in exchange for placing a hospital in its preferred network. Unfortunately for the hospital, it is often unclear as to exactly what being in that preferred network means. Unless the Preferred Provider Organization offers enrollees a specific incentive (e.g. a lower copay or deductible) to select an in-network provider, there is no real steerage of volume, and thus no reason for the hospital to offer a discount. A Preferred Provider Organization should not have a problem agreeing to contract language to that effect, and in those cases the hospital is making a reasonable exchange. There should not be a problem with contractual assurances that patients will identify themselves as a member of that Preferred Provider Organization at the time of admission through identification on their insurance card. This will help preclude retrospective revenue reduction for the hospital due to "silent PPOs."

Independent Practice Association-Hospital Transactions:

Contracts between an Independent Practice Association and a hospital often take into account special conditions and considerations that may exist between a hospital and its medical staff. Typically, the Independent Practice Association has taken financial responsibility for a set of services that the hospital provides, and it is now seeking a discounted rate for those services. The hospital needs to understand that the physicians may control not only the Independent Practice Association patient volume, but also volume

from non-managed care patients. The physicians must understand that an Independent Practice Association is not economically viable in the absence of a hospital contract. Independent Practice Associations typically seek steep discounts for outpatient services, and may also want the hospital to offer steep discounts to Health Maintenance Organizations. As the Independent Practice Associations grow and mature, they often look to capitate the hospital, and thereby pass on some of the price and utilization risk. In these arrangements, discounts to the Independent Practice Association should go directly to the hospital's physicians, while discounts to the Health Maintenance Organization are shared. It will also be critical to clearly define the division of responsibilities of the Health Maintenance Organization and Independent Practice Association. This will significantly affect the fees and rates in the contract.

Health Maintenance Organization-Independent Practice Association/Physician Hospital Organization Transactions:

In these agreements the Health Maintenance Organization is typically seeking to pass on risk to a group of physicians or a Physician Hospital Organization through capitation. The type of contract is usually a function of the relative strength of the Health Maintenance Organization and the physician group. The greater the relative strength of the Independent Practice Association/Physician Hospital Organization, the more risk they can demand, and the higher percentage of premium they can receive.

Preferred Provider Organization-Independent Practice Association and Individual Practitioner Transactions:

For these agreements, Independent Practice Associations and Individual Practitioners are grouped together because the Independent Practice Association is typically just executing the agreement for its members. The Independent Practice Association does not get involved in the claims submission and payment process. As in the Preferred Provider Organization-Hospital agreements, the Preferred Provider Organization is typically seeking either a 15%-30% discount, or offering physicians a set fee schedule. Most fee schedules are a derivative of Medicare's RBRVS system. For an individual practitioner, these are generally minimally negotiated. If the fee schedule is adequate, there is an element of patient steerage, and the Preferred Provider Organization has a strong local presence, then the contract may be acceptable.

For the Independent Practice Association/Physician Hospital Organization, there are additional considerations. Often, because the Independent Practice Association represents a large group of providers and because it can streamline administrative processes such as credentialing, the Independent Practice Association may be able to negotiate a non-standard fee schedule. Or, if the providers are well organized and the Independent Practice Association is used to managing utilization, it may be able to receive either a monthly utilization management fee or qualify for an annual utilization incentive payment.

Health Maintenance Organization and Independent Practice Association-Individual Practitioner Transactions:

These agreements are usually either discounted fee-for-service or capitation arrangements. Primary care physicians (PCP) are typically offered a capitation payment to provide all of a members basic care, and for management of their specialty care. Primary Care Physicians may, in turn, sub capitate specific components to other groups of providers such as rehabilitation providers. Capitation rates are age/sex adjusted, and may also be adjusted for copayments. Because the Primary Care Physician is taking utilization risk, they should be eligible for a utilization bonus at the end of the year.

For specialist providers including rehabilitation providers, the predominant reimbursement methodology is

still discounted fee-for-service. Most Health Maintenance Organizations and Independent Practice Associations have standard fee schedules with rates similar to Medicare's, or slightly higher for tertiary services. Because the specialist is not taking utilization risk, they are generally not eligible for a utilization bonus.

Capitation for specialist providers is more difficult than for Primary Care Physicians. The Independent Practice Association or Health Maintenance Organization desires capitation agreements because they successfully pass on all cost risk to another party. With the proper economic incentives established, the need for extensive utilization management is lessened, as is the need for claims processing and the monitoring of claims coding. There is a price to be paid for capitation's 15%-20% savings. Capitation forces the Primary Care Physicians to agree on using one group or one provider which can disrupt traditional referral patterns.

There may also be significant differences in the type of rehabilitation provider involved in the capitation discussions. A single private practice will be in a different negotiation position than a rehabilitation department of a hospital or integrated health system or a single site in a large rehabilitation network or regional rehabilitation corporation.

According to several sources, in medicine, not rehabilitation, for capitation to be economically viable for a specialist, there should be between 15,000 and 25,000 commercial members or more than 5,000 Medicare members, depending upon the specialty. Many of the small Independent Practice Associations simply do not have that many members. In addition, there is no guarantee that if a specialist receives a capitation contract, they will also receive fee-for-service referrals from those same Primary Care Physicians. On a long term basis, specialists, indeed almost all practitioners, will probably need to change their economic model so that they can operate profitably on capitation-level reimbursement. Figures similar to these that are specific to rehabilitation services are not available.

When executing a specialty capitation agreement, you, as the specialist, should look for a few key items:

- \$ Rates will be adjusted if the basic assumptions of utilization and intensity of service change
- \$ Annual utilization data will be considered in negotiation of the next contract
- \$ Utilization incentives exist because the you are bearing utilization risk
- \$ The Independent Practice Association is responsible for out-of-network usage within that specialty, not the specialist

Direct Contracting

Direct contracting of providers means a level and layer of the traditional health care system is bypassed. Direct contracting can involve a health plan that contracts with individual providers, bypassing provider organizations that otherwise might subcontract for this care. Direct contracting can also involve a self-insured organization that chooses not to contract with a Managed Care Organization to arrange its provider delivery system, bypassing the Managed Care Organization instead to directly contract with individual providers and provider organizations.

Integrated Delivery Systems

Integrated Delivery Systems involve a variety of ways individual and groups of providers can form together to deliver care as a more organized system. Sometimes these systems involve only physicians, who used to practice separately. They might band together under one roof as a medical group, merge their practices but continue to practice in separate locations, or just combine their management but keep their practices separate.

Physicians, hospitals and other providers can also form a combined organization to deliver various aspects of care.

Therapy Venues and Reimbursement Methodology

Having identified the options for reimbursement relationship between payer and provider, it will be necessary to identify the typical relationships that exist for rehabilitation providers in the real world. It is important to note that due to the changing nature of reimbursement and the significant geographic differences, there are few, if any, absolutes in describing reimbursement relationships in the various venues for rehabilitation practices. For every generalization that we can suggest, there will be a substantial number of exceptions. Our attempt here is not to specifically define the relationship between your practice and an individual payer, but rather to identify common financial relationships between typical practices and payers.

Please note that The Balanced Budget Act of 1997 will change some of the financial relationships we will describe here. Our attempts are to describe current, not future, relationships. In light of the potential for amendment or adjustment of current legislation and regulation, this is the only prudent path to follow.

Please refer to Chapter 7 for information about the changes in Medicare and Medicaid due to the Balanced Budget Act of 1997.

Due to the nature of printed materials and the lag time for production and distribution, other, more timely media should be considered. Refer to our Internet web page at www.TheFOCUSGroup.net for ongoing contemporary information on this topic.

**Reimbursement Methodologies
in Different Practice Settings for Rehabilitation Providers**

We will examine the typical reimbursement methodology for the following practice settings. No attempt is made to differentiate between the various type of rehabilitation disciplines for the purposes of this discussion.

- Acute Inpatient Care
- Hospital-based Outpatient Rehabilitation Agency Outpatient
- PTIP/OTIP Outpatient
- Comprehensive Outpatient Rehab Facility
- Community Home Care Agency (Includes Hospital-based Home Care Agency)
- Skilled Nursing Facility (SNF) (Includes Sub Acute Rehabilitation)
- Inpatient Medical Rehabilitation Programs

For the purposes of this discussion, we will assume that Skilled Nursing Facility rehabilitation services will be similar to Sub Acute Rehabilitation services. This may not be true in all geographic areas. We will also assume that Community Home Care Agency rehabilitation services will be similar to Hospital-based Home Care Agency services. This is very likely to be consistently true in most cases. The Physical Therapist in Independent Practice (PTIP) and Occupational Therapist in Independent Practice (OTIP) classifications are assumed to be similar in the **type** of financial relationships that they have with payers, although PTIP and OTIP do not always the same reimbursement rates.

We will examine the typical financial relationship between the above types of rehabilitation providers with the following typical third party payers.

- Medicare (Traditional)
- Medicaid
- Workers= Compensation
- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Point of Service Plan (POS)
- Traditional Indemnity Insurance

Reimbursement Models in Rehabilitation Clinical Practice

AU Note: This Chart may be outdated in 2011

Venue	Reimbursement Model						
	Medicare (Traditional)	Medicaid ²	Workers = Comp ¹	HMO ²	PPO ²	POS ²	Traditional Indemnity Insurance
Inpatient Acute Hospital	PPS/DRG	PPS/DRG ³	FS ³	FS ³	FS	FS	FS
Hospital Outpatient	CR	CR ³	FS ³	FS ³	FS	FS	FS
Rehab Agency Outpatient	CR	CR	FS	FS ³	FS	FS	FS
PTIP/OTIP Outpatient	FS	FS	FS	FS ³	FS	FS	FS
Comprehensive Outpatient Rehab Facility (CORF)	CR	FS	FS	FS ³	FS	FS	FS
Community Home Care	CR ³	CR ³	FS ³	FS ³	FS	FS	FS
Skilled Nursing Facility	CR	PPS/PD	FS	FS ³	FS	FS	FS
Inpatient Acute Rehabilitation Hospital/Unit (PPS Exempt)	CR/T	FS ³	FS	FS ³	FS	FS	FS

Key

- FS Fee Schedule/Fee for Service (may include a discounted fee for service arrangement)
- CR Cost Reimbursement
- C Capitation
- CR/T Cost Reimbursement subject to TEFRA cap
- PPS Prospective Payment
- PPS/DRG Diagnosis Related Groupings
- PPS/PD Per Diem rates
- CC Case Capitation

Note: Changes due to The Balanced Budget Act of 1997 are not included in this table. Refer to Chapter 7 for the impact of BBA97 on rehabilitation reimbursement methodologies.

- 1 Varies by state - See listing of State Insurance Authorities in Appendix for more details
- 2 Typical arrangements noted - Will vary by contractual arrangement.
- 3 May also be capitated as part of larger capitation plan

PTIP = Physical Therapist in Independent Practice
 OTIP= Occupational Therapist in Independent Practice

Rehabilitation Reimbursement in A Health Care Continuum

There are tremendous incentives to providers to develop a continuum of care. One additional recent incentive is the change that is being implemented in the aftermath of the Balanced Budget Act of 1997. These changes will be fully addressed in Chapter 7.

As health care systems shift from a point of delivery focus to a continuum of care view, rehabilitation clinicians and managers' roles and responsibilities are shifting dramatically. Until recently, managers needed only to understand a specific level of care, its delivery system, its culture and its specific reimbursement structure. With the shift to a full program of services, it is now critical that clinicians and managers be able to link each level of care together and, more importantly, to understand the inherent differences of each level to allow for successful integration of care delivery.

When a reorganization places responsibility for a continuum of services in one place, it is expected that the interface of services will become smooth. Unfortunately, this expectation is often unrealistic. This happens because before integration occurred the management and staff of each level of care interacted only in peers groups. Trade associations, local contacts, etc., all tended to come together from a particular business perspective.

Venue specific jargon and the *Medicare Conditions Of Participation* act to maintain the separateness of each level. This results in the belief that managers and clinicians from other levels of care really do not understand their colleagues from other levels. These groups refer patients to each other, but this tends to be the extent of the interaction. The result is that each level of care has its own culture and reimbursement structure.

Understanding these differences and developing plans to minimize their impact is critical to a successful integration process. Next is a look at five service levels often included in a provider system's continuum of care. As we review remember that this is a description of reimbursement prior to the enactment of changes required by The Balanced Budget Act of 1997.

Acute Inpatient Services.

Acute inpatient services have changed dramatically since the advent of prospective payment through the DRG system in 1983. The provision of inpatient acute care services focuses primarily on the diagnosis

and short-term treatment of injuries or illnesses. An institutional culture is often prevalent with management and staff, and department goals are focused on organizationally established performance levels. Physician relationships within all specialties is a driving force. As the post acute levels of care grow, many acute care facilities are downsizing.

Finally, given the high acuity of most acute care patients, there is a long-standing tradition of patient care based on "care giving" rather than "care management." Reimbursement has initiated short lengths of stay, and physicians and others are constantly being pushed to move patients quickly. Thus, the first acute levels of care become places to refer to, not link with.

Rehabilitation Units and Hospitals.

Rehabilitation hospitals and units are reimbursed by Medicare under TEFRA (Tax Equity and Fiscal Responsibility Act). A per-discharge payment amount is established based on the facility's or unit's actual costs. If actual costs are less than this amount, the provider receives an incentive payment. If actual costs are more than this so-called "target rate" amount, providers receive actual costs plus a minor adjustment. In addition, if a rehabilitation unit or hospital does not strictly adhere to the Medicare rules of participation, which govern patient types and program requirements, the facility could be forced into the diagnosis-related group (DRG) payment system, a highly unprofitable situation.

From a patient care standpoint, rehabilitation is steeped in the tradition of minimizing disability through an interdisciplinary approach to care. Rehabilitation professionals place high value on team (including patient and family) interaction. Supported by accreditation criteria and regulations, patient advocacy is a strong component of the program. Its reimbursement structure and Medicare-mandated admission requirements differ from those in other inpatient units. Today, some rehabilitation programs deny admission to about 50 percent of referrals from acute care hospitals.

Hospital-based units are often frustrated by inappropriate referrals and accusations of being difficult. They walk a fine line between being a separate provider within the hospital and an integrated unit within the overall system. Additionally, unlike acute care, rehabilitation managers and staff usually interact with only a handful of physicians. While this may make it easier to work as a strong team, it also call exacerbate the potential lack of understanding between the unit and the rest of the system.

Traditionally, freestanding rehabilitation hospitals have been more entrepreneurial than their hospital based counterparts because they have had to depend on more than one facility for patients. However, as health care networks develop, most rehabilitation hospitals are finding themselves with a need to affiliate with one network. As this occurs, they begin to look and act similar to rehabilitation units.

Skilled Nursing Units and Facilities.

A skilled nursing unit and facility is paid on a routine cost limit plus ancillary services at cost basis by Medicare. The routine cost limit, which covers nursing, dietary, routine supplies, housekeeping, etc., is higher for a hospital-based unit than for a freestanding facility. Traditionally, the pay scales for nursing home professionals are less than those for hospital-based professionals, which may add to problems among members of an integrated care team.

Skilled nursing units and facilities have traditionally been used for chronic care patients who require extended nursing services. The growth in subacute rehabilitation programs has changed the mission of many facilities who now provide a much higher acuity medical and rehabilitation service. Many skilled nursing providers are, in fact, rendering services quite similar to those provided on traditional medical/surgical units or in acute rehabilitation units. Management and staff may actually see themselves in

competition with the acute and rehabilitation components of the systems.

Further, as with rehabilitation, the Medicare conditions of participation have specific requirements for admissions which often confuse referral sources and create frustration. For example, a Medicare patient must have a three-day qualifying acute care stay before being admitted to a skilled bed, but the patient may be admitted directly to the skilled bed if he or she is enrolled in a Medicare managed care plan. The hospital-based skilled nursing unit is usually focused on meeting the needs of its host facility, thus providing a variety of care depending on the needs of the patients. Freestanding skilled nursing facilities often serve a variety of referral sources and can specialize and limit inappropriate admissions with more ease than their counterpart. Still, a misunderstanding of capabilities and appropriate admissions is a common occurrence, and staff attitudes and beliefs may reflect these issues.

Home Health Services

Home health services range from the provision of skilled care through high-tech services and ancillary care support. Unlike all other levels of care, this one does not occur in a specific, set location, but in the patient's home. Thus, home care providers' perspective of care and treatment are personal and direct to the patients they serve. The home setting requires that home care personnel be creative in managing patient care with little equipment or space, often in inadequate (and sometime dangerous) surroundings. There is also a dependency on care giver (often the patient's closest family member)- not professional- follow through for outcome management.

Often home health services are provided through a separate legal entity from the host facility or through a freestanding agency. This lack of specific treatment location and the separateness of operations creates a culture different from that of the hospital. The home care agencies are focused on geographic coverage, market share and service delivery. While entrepreneurial in nature, home care also is nursing-intensive, resulting in a unique perspective of the market. Rehabilitation often represents less than 20% of the agency's business volume and therefore may lack significant influence in a nursing dominated industry.

Inpatient components of a health care delivery system depend on home care to support a discharge to home. However, few understand the treatment constraints associated with home care. Because Medicare reimbursement does not currently mandate the number of home care treatments authorized, there is little or no incentive for these agencies to refer to ambulatory programs. Thus, as systems of care grow, these agencies can easily be viewed as competitors of outpatient options. There is likely to be significant changes as The Balanced Budget Act of 1997 is implemented.

Outpatient Services

The focus of these programs can vary widely from the treatment and management of acute injuries involving patients with no prior acute care stay (a sports related injury, for example) to follow through of an inpatient treatment process (stroke rehabilitation, for example). Day hospitals, full medical and therapy-based programs, are growing within the outpatient environment, and so are traditional outpatient programs. Outpatient treatment settings, also can vary from hospital, based to freestanding programs. The culture of most outpatient programs and facilities is entrepreneurial, but hospital-based programs tend to focus service more on the follow-up of acute care patients than developing an independent patient base. Competition can be fierce, and physician relationship maintenance and development is a critical focus of staff and administration. Many outpatient providers are frustrated that they do not get patients as soon as they think they are appropriate for outpatient care, believing that the in patient and home care providers are keeping the patients longer than necessary.

Medicare reimbursement varies greatly depending on the certification of the program. Regardless of the actual certification, outpatient programs and services are reimbursed Medicare Part B. Patients pay a co-payment. Because there is less out-of-pocket expense for the inpatient and home care levels, patients may opt out of ambulatory services until reimbursement pressures mandate participation.

Implications of Reimbursement Methodology on Rehabilitation Providers

It is very important to understand the role that financial risk plays in the exchange between payer and provider. One of the cornerstones of managed care is, to varying degrees depending on MCO type, the integration or merging of payer and provider. As risk is shared by or transferred to the provider from the MCO, the provider begins to take on the appearance of an insurer.

As rehabilitation providers enter into discussions with MCOs regarding inclusion on provider panels and assumption of risk, it will be necessary to understand the implications of the various forms that the payer-provider relationship can take.

Summary

It is critical to understand the relationship between payer and provider in order to effectively manage that relationship and the financial components associated with it. In this chapter, we have tried to define alternate mechanisms for payers and rehabilitation providers to developing successful financial relationships. As we move into the strategic management of those relationships in the next two chapters, it will be helpful examine our challenges and opportunities in the context of these simple relationship models.

Case Study

How Much Do I Charge?

Background

You work in a typical outpatient clinic that routinely sees orthopedic patients. Your patient is a weekend athlete in his mid 40's with a partially torn left medial collateral ligament. The injury occurred while playing tennis three weeks ago and he was seen immediately by an orthopedic who placed him in an immobilizer NWB for 10 days. He now ambulates independently with a minor limp. He wears no bracing or ace wrapping. He has full active knee extension and 115 degrees of active knee flexion. He has tightness in the hamstrings, quads, and gastroc/soleus muscles. There is no edema, echymosis, or skin integrity changes. There is minimal VMO atrophy, and strength of the quad, VMO and hamstrings is 4/5. Patellar tracking is normal. There is mild tenderness at the mid portion of the MCL and a +1 valgus test. No pain is reported for any activity and he can ascend stairs but reports some difficulty with descending. All other special tests of the knee are negative. There is no significant past medical or surgical history; and he desperately wants to return to playing weekly tennis ASAP as his "buddies need him".

Design the highest quality and most cost effective program possible.

1. What will the treatment consist of? There can be no more than 8 total visits.

Visit	Treatment to be Provided	Care Giver				Comments
		PT	PTA	ATC	Aide/ Tech	
Visit 1						
Visit 2						
Visit 3						
Visit 4						
Visit 5						
Visit 6						
Visit 7						
Visit 8						

2. How much of whose time does it take to provide this type and intensity of care?

Hours of Care	PT	PTA	ATC	Aide/Tech	Other	Total
Visit 1						
Visit 2						
Visit 3						
Visit 4						
Visit 5						
Visit 6						
Visit 7						
Visit 8						
Total						
	(2PT)	(2PTA)	(2ATC)	(2Aide)	(2Other)	(2Total)

- Are there other clinical consumable supplies that are used in the care of this patient? What are they and what will they cost for the total episode of care?

Supply Item	Cost of Supply Item
Total	(3)

- What are your hourly labor costs?
 Assume overhead and benefits is an additional 25% of hourly rate for each job classification.

Salary (per hour) for PT = _____ X 125% (Overhead & Benefits) = _____ Cost/Hour_ (4PT)

Salary (per hour) for PTA = _____ X 125% (Overhead & Benefits) = _____ Cost/Hour_ (4PTA)

Salary (per hour) for ATC = _____ X 125% (Overhead & Benefits) = _____

Cost/Hour_
_____ (4ATC)

Salary (per hour) for Aide = _____ X 125% (Overhead & Benefits) =

Cost/Hour_
_____ (4Aide)

Salary (per hour) for Other = _____ X 125% (Overhead & Benefits) =

Cost/Hour_
_____ (4Other)

- What are your labor costs for the episode of care?

Hours for PT = _____ X Cost per hour _____ (Put 4PT) = Labor cost _____
(5PT)

Hours for PTA = _____ X Cost per hour _____ (Put 4PTA) = Labor cost _____
(5PTA)

Hours for ATC = _____ X Cost per hour _____ (Put 4ATC) = Labor cost _____ (5ATC)

Hours for Aide = _____ X Cost per hour _____ (Put 4Aide) = Labor cost _____
(5Aide)

Hours for Other = _____ X Cost per hour _____ (Put 4Oth) = Labor cost _____ (5Other)

Total Hours _____ **Average Cost/Hour** _____ (5Ave) **Total Labor Cost** _____ (5Total)

- What method will you use to determine a charge for your services?

Choices:

Fee per treatment _____ At what rate per treatment? (Use worksheet)

Charges for Individual Treatments in Fee per Treatment Model	
Type of Treatment	Charge rate

Fee per visit _____ At what rate per visit? _____
Case rate _____ At what rate per case? _____

Note: *Capitation is not considered in this example, but may be a potential model to use.*

- What is your gross profit on this case?

Method of Charging	Total Cost of Care (Include labor and supply costs)	Total Revenue per Case	Gross Profit (Subtract Total Cost from Total Revenue)
Fee per treatment			
Fee per visit			
Case rate			

- How will you price this care?

- What could you do to price the care lower?

Sample Relative Values of Typical Physical Therapy Treatments

Au Note: This chart uses 1998 Values

Treatment Type	Relative Weight Compared to Base of Exercise at 1.000
Cold Pack <i>(Value to Zero as of 1/1/97)</i>	0.538
Hot Pack <i>(Value to Zero as of 1/1/97)</i>	0.538
Ultrasound	0.545
Paraffin Bath	0.593
Iontophoresis	0.687
Electrical Stimulation	0.722
EMS	0.722
Pelvic Traction	0.748
Cervical Traction	0.748
Whirlpool	0.748
Massage	0.787
Gait Training	0.873
Manual Traction	0.960
Therapeutic Exercise	1.000
Neuro Rehabilitation	1.000
Therapeutic Activities	1.046
Evaluations - Initial and re-evals	1.182
IsoKinetic Test	1.182
Myofascial massage	1.363
Mobilization	1.363

Clinical Strategies in Physical Rehabilitation for Managed Care

Overview

In this chapter, we will review those aspects of managing a rehabilitation practice that directly affect the clinical care that is delivered. These areas are often quite controversial to staff and clinical management but, nonetheless, are important components of a successful managed care strategy. In this chapter we will focus on clinical management programs, case management programs, utilization management programs, outcomes management programs, quality management programs, credentialing, productivity programs and accountability programs. Although several of these topics are very closely related and often interwoven with each other, we will address each separately. It is the hope of the authors that the interconnectedness of these topics is not lost to the reader because of this structure. Finally, we will address the role of continuing clinical education in the managed care environment and identify some of the challenges that the successful practice will need to address to succeed.

Preview of Major Topics

Clinical Care in Managed Care

Clinical Management in Managed Care

- Market Response

- Financial Response

- Provider Satisfaction

- Member Satisfaction

- Data Needs

- Clinical Management Components

- Resource Management

- Quality Management as a Component of Clinical Management

- Information Management

- Resources Required for Clinical Management

Case Management in Managed Care

- Organizational Use of Case Management

- Managed Care Use of Case Management

- Case Management Program Characteristics

- Organization

- Policies and Procedures of Case Management Programs

- Links of Case Management to Other Departments

- The Nature of Case Management

- Use of Case Management in Rehabilitation Practice

- Legal Implications of Case Management

- Development of Case Management Programs

- Clinician Buy-in for Case Management Programs

Utilization Management in Managed Care

- Referral Management

- Scope of Practice Management

- Referral Guidelines

- Authorization
 - Service Authorization
- Outcomes Management in Managed Care
- Quality Management
 - Definitions in Quality Management
 - Quality Drivers in Managed Care
 - Characteristics of Successful Quality Programs
- Credentialing in Managed Care
 - Clinician Requirements
 - Non-Physician and Provider Requirements
 - The Credentialing Process
 - Delegated Credentialing
- Accountability Management in Managed Care
 - Accountability Framework
 - Accountability Mechanisms
 - Provider Contracts
 - Accreditation
 - Federal Accountability
 - State Accountability
 - The Legal System
 - Marketplace Demands

Clinical Care in Managed Care

Because of the inherent relationship between provider and payer in a managed care system, it is often difficult to confidently answer the question, Who makes the clinical decisions concerning our patients? There is often a significant tension between the various players who step onto the managed care playing field. In managed care, it is necessary to clearly decide where the locus of patient decision-making and control is - with the Primary Care Physician, the rehabilitation practitioner, or with the Managed Care Organization? There is a significant argument possible for each to exert significant influence, if not control, over the care provided to the patient. The rehabilitation practitioner, usually a therapist, has had the advantage of advanced training and intensive interaction, evaluation, and assessment of the individual patient. It is clearly the rehabilitation practitioner's responsibility to develop a therapeutic plan of care and to assure that it is carried out. The primary care physician is often responsible to manage the care of the patient across the entire health care spectrum. These gatekeepers are often thought of as the manager in the managed care system. Clearly, it is necessary to involve the primary care physician in the decision processes that affect the delivery of care to the patient. The Managed Care Organization, as the financier of the care, has a strongly vested interest in seeing that appropriate care is delivered in the appropriate amount, at the appropriate time and place as cost effectively as possible. Within managed care, as well as many other worlds, the golden rule applies, at least to some degree. He who has the gold, makes the rules. How the parties involved in clinical decision making concerning a specific patient resolve these inherent areas of conflict will determine the eventual success or failure of the clinical care delivered to the patient. In this chapter we will review some of the most common mechanisms to address and resolve some of these potentially adversarial clinical positions.

Clinical Management in Managed Care

Clinical management programs are crucial to the performance of rehabilitation provider groups which engage in managed care activities. The structure, focus and sophistication of a clinical management program is dependent upon your organization, the amount and type of financial risk involved, and the staff reimbursement and incentive structure.

A clinical management program consists of a series of activities undertaken by clinicians and managed care organizations (MCOs) to maintain or improve quality and service levels, meet budgetary projections, and respond to accreditation and regulatory requirements.

The nature of clinical management programs today contrasts sharply with those of the past. Historically, clinical management consisted of a few basic approaches: minimal credentialing, quality assurance screens for adverse events, and utilization review focused on the length of stay.

Today's clinical management programs have a much broader scope, designed to integrate comprehensive quality improvement activities with effective utilization management across the full continuum of care. This expansion reflects an increased emphasis on clinical and service quality, continued refinement in technology, expanded information processing and provider adaptation to clinical management requirements. Typical clinical management activities may include:

- § Preventive activities and coordination with Managed Care Organization member services departments to identify at-risk members.
- § Programs to increase rates of preventive services and screenings. Targeted demand management and disease management programs focused on specific subsets of the population, such as members with history of musculoskeletal injury, chronic disease, children with disabilities or general deconditioning. Sophisticated data analysis to achieve effective management and to identify optimum processes of care for the patient population.
- § Treatment guidelines and protocols. Outcome measures, including patient quality of life and functional status. Provider profiling and feedback to support process improvement. Process improvement focused on access to care and service.

There are several compelling reasons for providers to develop clinical management programs, requirements mandated by the nature of managed care contracting:

Market Response

The National Committee on Quality Assurance (NCQA) has advanced the accreditation process for managed care organizations across the nation. Assessing the credentialing, quality management and utilization review functions has been part of NCQA standards since its inception. As the standards have evolved, the number of Managed Care Organization functions to be considered in the accreditation process has increased and expanded. And this accreditation is becoming a necessity for a Managed Care Organization to remain competitive in those markets where other Managed Care Organizations are already accredited.

The presence of NCQA standards in the market place has had a trickle-down effect on those organizations which contract with managed care organizations. NCQA details the manner, scope and degree with which Managed Care Organizations relate to their contracted providers: The standards require the development of partnerships to monitor and oversee clinician performance, including credentialing, and quality and utilization management. In fact, the importance of the clinician role in maintaining the Managed Care Organization's accreditation is underscored by NCQA's initiation of an accrediting process for clinician organizations. It is anticipated that they will include rehabilitation providers in the coming years.

Financial Response

As Managed Care Organizations have matured, trends have developed which have had an impact on clinical management:

Providers have expanded the risk they will accept. Managed Care Organizations have increased their expertise in the management of more complicated cases, such as traumatic brain injury and neurorehabilitation, and are focusing their own clinical management on the more complex, leaving clinician groups to assist with the management and monitoring of more common services. HEDIS measures have encouraged provider organizations to assess the use of preventive services and develop strategies to increase that use. HEDIS stands for Health Employer Data Information Set, and is designed to report on the frequency of preventive services for relevant populations.

The adoption of expanded risk by providers has required them to develop systems and processes to manage utilization of those services for which they are at risk. Additionally, Managed Care Organizations have encouraged provider organizations to enhance quality management activities by providing financial incentives for selected quality activities.

As Managed Care Organizations have focused their attention on the high-cost rare events, provider organizations have responded by developing their own clinical management. The emphasis on preventive care will, over time, lower the risk for selected patient populations, and decrease the secondary effects of disease.

Provider Satisfaction

A well-developed clinical management program must be both administratively efficient and clinically sound, as well as relevant to the therapist and patient populations being served. The program's policies and procedures guide and support the clinician in making clinical decisions. Thus, therapists must be encouraged to participate in their development and ongoing improvement.

Member Satisfaction

Clinical management programs promote satisfaction through the provision of tools to assist members in staying well, optimal management of chronic or episodic conditions, and provision of support and service coordination during times of acute crisis. For example, one such tool is a case manager who explains the course of treatment, assesses benefits to optimize coverage, coordinates care, and is available to answer questions that arise as members move through levels of care is appreciated by those who require it.

Data Needs

Clinical management program outcome data can assist other areas in their performance. In a Managed Care Organization, utilization data forms the basis for underwriting, rate setting, determining incentive payment, or withholding returns. In a provider organization such data is used to determine adequate capitation and target areas for improvement. Quality management outcomes support credentialing and incentive payment decisions for both types of organizations.

Clinical Management Components

Clinical management programs focus on service delivery and maintaining high levels of customer satisfaction, often surveying members regarding their satisfaction with care, the process used to arrange care, and the

vendors who provide the care. Managed Care Organization clinical management programs seek to identify at-risk patients, and then reduce that risk and promote appropriate access to care.

Risk appraisals are often conducted with the Managed Care Organization to identify new members who require intervention to stay well, or who may need assistance coordinating their care as it is assumed by network providers. Clinical treatment guidelines and protocols are developed to provide support for optimum treatment, including options for rehabilitation treatment, patient education, and self care.

Resource Management

Case-by-case review is conducted to assess the clinical necessity of a proposed procedure or service.

Effective resource use is enhanced through the following types of activities:

- § **Treatment Pre-certification.** As more services move to an outpatient setting, there is an increased necessity to efficiently control outpatient utilization. Pre-certification requires the use of clinical criteria to determine the clinical necessity of a proposed care plan.
- § **Referral Management.** Referral management processes are changing. Some clinician or managed care organizations review all referrals. Very few capitated programs advocate direct member access to rehabilitation. The option chosen depends on network organization, referral volume by specialty and specialist, and reimbursement mechanisms.
- § **Case Management/Discharge Planning.** During the pre-certification process, members who may need ongoing care are identified. Early identification enables the tailoring of the treatment plan to the patient's needs, assuring adequate patient education and facilitating transition between levels of care.
- § **Treatment Guidelines.** These provide the tools to identify optimum treatment methods for select conditions, to coordinating the use of health care resources for patients with significant care requirements, for maximum gain. Rehabilitation specific examples of these are The Guide to Physical Therapist Practice, Part 1 and Part 2 published by the American Physical Therapy Association and The TAI Rehabilitation Guidelines published by Therapeutic Associates, Inc.

Quality Management

Quality management and improvement will be discussed in much greater detail later in this chapter.

Effective quality management programs typically incorporate the following into their structure:

- § **Indicator Monitoring.** Quality management includes the monitoring of indicators which have been selected based on accreditation/regulatory requirements and organizational priorities. Indicators are typically focused on clinical outcomes, resource utilization, quality of care, access, and member satisfaction.
- § **Medical Record Review.** Medical record review, using established parameters, can be utilized in peer review or in support of credentialing and re-credentialing activities.
- § **Clinical Evaluation Studies.** Performance information from other medical record review or claims data is analyzed to further determine appropriateness of care.
- § **Patient/Provider Satisfaction Surveys.** Surveys are conducted periodically of both patients and providers to determine how the organization can improve its service. Results are forwarded to those responsible for responding to the results.
- § **Medical Record Review.** Reviews with established parameters can be utilized in peer review or in support of credentialing and re-credentialing activities.
- § **Medical Evaluation Studies.** Performance information from other medical record review or claims data is analyzed to further determine appropriateness of care.

§ **Committee Support.** Utilization and quality issues are addressed, solutions identified, and progress monitored through interdepartmental committees, the number and type varying with the complexity of the organization. Management staff typically provide the support and information for the committee work.

Information Management

A critical component to success clinical management programs is the use of data and clinical information efficiently. Components of the information aspect of clinical management include:

- § **Data Analysis and Tracking.** This provides a level of understanding about processes and outcomes of care, and provides an understanding of current utilization and cost patterns as they relate to historical patterns or external outcomes.
- § **Refined Outcome Measures.** Through experience and data collection, Managed Care Organizations and provider organizations can begin to determine what works best for their patient population. Outcomes can be defined in terms of functional status -- the patient's quality of life.
- § **Therapist Profiling.** Profiling clinicians on costs, utilization and quality indicators assists the organization to determine clinical management priorities, including providing feedback to the clinician to improve performance.
- § **Credentialing/Recredentialing.** The process should include primary source verification, site visit, and medical record review. Recredentialing verifies information, and reviews such quality outcome measures as utilization performance, and patient satisfaction levels.

Resources Required for Clinical Management

The resources required to develop and maintain a clinical management program depend on program goals.

Many resources are already available within the organization:

- § Human Resources, such as Licensed therapists, Registered nurses, Management staff, Analytical staff and Clerical staff
- § Capital Resources. Management information system with a database capable of supporting the review process, including the analysis and reporting of quality and utilization data. Telephone system with reporting capability. Fax transmission capability.
- § Other resources including clinical necessity criteria, preventive care guidelines, treatment guidelines, patient and provider satisfaction surveys and utilization review and management.

Case Management in Managed Care

The term "case management" is frequently used when describing an approach for managing complex clinical care. Case management has been defined as "... a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health care needs using community resources available to provide quality and cost-effective outcomes." This definition describes a complex, multi disciplinary process that requires the input and support from many players in the health care delivery system, including patients, their support system such as the family and friends, all care providers, and vendors and/or other suppliers to the health care system. All work in a coordinated way to achieve agreed upon goals for the patient.

Organizational Use of Case Management

Case management is not unique to rehabilitation organizations. Many different types of organizations use the case management approach:

- § Hospitals employ a case management process to manage the use of inpatient resources. Clinical pathways, which describe the services and activities appropriate for a diagnosis, are used to guide treatment during inpatient stays. The guidelines' design is consistent with "best practice". Practitioners use them to help manage the length of stay and service usage.
- § Managed care organizations (MCOs) use case management to coordinate complex clinical care. Historically, Managed Care Organizations focused on small patient populations with catastrophic conditions that consumed disproportionate health services dollars. This type of case management is known as large case management.
- § Worker's compensation carriers may use case management to organize the physical and vocational rehabilitation of a worker injured on the job. Efficient arrangement of clinically necessary services promotes optimal patient outcomes. This approach can reduce the period of disability, and assure a high quality of care at an appropriate cost.
- § Community-based organizations use case management to establish client linkages to reimbursement programs, to increase access to medical, social, or vocational agencies in order to resolve issues of medical care, housing and employment. Case managers in these programs are usually more skilled at meeting the social needs of patients than their clinical needs. Providing transportation and assuring clients keep their appointments at the various agencies are important components of their activities. This type of case management is probably the most established of all. It has provided the foundation for other care providers to adopt their techniques.

Despite the different approaches of the various types of organizations to case management they similar in a number of ways:

- § All influence patient utilization through the type of services and systems of care.
- § All focus on the organization and sequence of services, plus the resources needed to respond to individual concerns.
- § All use the expertise of multiple professionals
- § All reflect the needs of the target populations

Managed Care Use of Case Management

Case management is a cornerstone of managed care throughout the country. Case management is attractive to managed care organizations because of its ability to respond uniquely to each individual, to arrange services with quality providers that are consistent with the benefit plan, and to contain costs. Properly done, case management can align the interests of the patient, the clinician and the payer alike. Today most Managed Care Organizations focus their case management programs on the small percentage of the population that consume an inordinate amount of resources. This often includes rehabilitation patients. Originally, case management focused largely on patients with catastrophic illnesses or injuries. However, the emergence of the National Commission for Quality Assurance accreditation standards (NCQA), and the enrollment of Medicaid and Medicare populations in managed care plans, have encouraged Managed Care Organizations to rethink their case management strategies. The use of case management for catastrophic illness or injury still occurs, but programs have begun to focus more intensely on conditions that are more prevalent in the population.

NCQA guidelines encourage Managed Care Organizations to demonstrate their awareness of the health care needs of the population they serve, and to implement measures to improve health status. One way

Managed Care Organizations have done this is through the implementation of clinical management programs for prevalent conditions. At the core of disease management is a plan that describes what health care professionals should do. For example, a chronic pain management guideline would include: visit frequency, medications, patient education content, methods to monitor treatment response, and frequency of contact by the case manager. This is also true of rehabilitation management. Between visits to the health care provider, the case manager assesses patient compliance with the treatment plan, measures patient response, and assists with problem resolution.

The enrollment of Medicare and Medicaid populations has encouraged Managed Care Organizations to develop the infrastructure and community linkages that are critical to serving these populations. Case management programs for these individuals focus on the impact of social and economic factors that interfere with a patient's ability to comply with the treatment plan, e.g., patients who may not be able to afford the transportation for doctor visits may wait until their condition has deteriorated to a point where an ER visit is required.

Medicare members may require special interventions, with activities focusing on services and approaches to avoid premature institutionalization. Linkages to community-based agencies to provide assistance with the activities of daily living and home-based clinical care may be implemented to maintain the independence of the "frail" elderly.

Case Management Program Characteristics

A well-run case management program, is organized and staffed appropriately, has well developed policies and procedures, has an internal evaluation mechanism, and interfaces appropriately with other departments such as provider relations, claims and member services.

Organization of the Utilization Management Function

In many Managed Care Organizations, the case management function is part of utilization management. If a Managed Care Organization has dedicated case management staff, they may interact with staff performing precertification or concurrent review. Cases identified as potential case management are routed to the case manager for further assessment and possible case management implementation. As the target population needing case management techniques increases, there may be opportunities for case managers to work with members of the quality staff or to interact with disease management work groups.

Registered nurses (RNs) frequently act as case managers, and traditionally have been preferred because of their clinical knowledge, their ability to think holistically, and their use of a scientific problem solving approach.

Of course, the financial and organizational skills required of case managers must be obtained through other means, such as prior experience or special training. Social workers are also valuable as case managers, especially with patients who have socially or economically complex situations. Case managers with this type of background can also manage the clinically complex patients with appropriate training. Rehabilitation practices need to supplement any external case management system with strong internal case management. External case management from the Managed Care Organization is designed to protect the interests of the Managed Care Organization, not the practice. Case management that is internal to the rehabilitation provider's practice is especially critical if the practice has accepted any financial risk for patient care.

The number of case managers required (either internal or external to the practice) depends upon the number and type of the practice's patients. While specializing in a particular area of case management is

always possible, Managed Care Organizations may be better served to encourage case managers to function as generalists, which will assist with case assignment and facilitate timely implementation. For small practices, a single generalist case manager may be the only choice.

Active case management programs enable patients to maintain the highest level of functions for as long as possible.

In addition to the quantitative aspects of program performance, the satisfaction of the patients and the providers should be accounted for. If the program assists with keeping utilization rates within the appropriate target, but alienates clinicians and patients, then the program can hardly be considered successful over the long term.

Treatment Guidelines in Managed Care

In some circles, treatment guidelines are wildly heralded; in others, they are deeply mistrusted. Despite reported benefits of cost reduction and healthier outcomes, some segments of the industry remain skeptical about their value. Some clinicians view attempts to map out processes of care as a restriction on their professional judgement, often citing that these tools are nothing more than "cookbook@ medicine. Even in the face of such resistance, most managed care organizations are devoting resources to the development and introduction of treatment guidelines for two reasons:

- § Treatment guidelines are conceptually sound and seemingly logical. Getting practitioners together to define the process of good care makes sense.
- § Treatment guidelines interface with the activities of the National Committee for Quality Assurance (NCQA) to improve the health outcomes of the members served by managed care organizations. As a result, the issue is not whether treatment guidelines are inherently good or evil, or whether they should be implemented or not, but whether they are appropriately used to improve the functional status of the rehabilitation patient population.

Treatment guidelines and other forms of standardizing care are differentiated in the following ways:

- § Treatment guidelines focus on outpatient activity, and guide clinician decision making over time. They cover health maintenance, prevention, diagnosis, treatment, patient education, and patient self-care.
- § Clinical or Critical Pathways are procedure based, tend to be focus on inpatient care, and coordinate the activities of a multi disciplinary team. The only decision making is whether the patient should enter and or stay in the pathway; all the subsequent steps are already established.
- § Clinical Protocols are specialty oriented, and focus on outpatient care. They serve as a consensus guide to clinicians in treating unusual disease problems that occur relatively often in specialty clinics.

Use of Treatment Guidelines In Practice

Treatment guidelines assist clinicians in making decisions about appropriate rehabilitation care for specific clinical circumstances. They are not standards or rules. They can be as simple or as detailed as a practice believes is necessary to provide good care to patients and to consistently monitor how well care is provided.

Treatment guidelines are particularly helpful in the following areas:

- § Comparing different patterns and approaches, to reduce variability in care;
- § Facilitating communication among clinicians about clinical issues;
- § Discovering the points where clinical and administrative procedures interface;
- § Planning how to improve clinical processes, to increase the cost effectiveness and appropriateness of care;
- § Educating or transmitting information about agreed-upon methods.

Treatment guidelines are not helpful when they are applied in a piece-meal fashion, when they are not connected to quality improvement efforts, or when they are introduced without the active support of the clinicians. They are not intended to reduce clinical science to simple, routine formulas. Rather, they are tools designed to facilitate clinical treatment planning and utilization decision making. It is widely recognized that treatment guidelines are not appropriate for all cases. It is the responsibility of the individual therapist to know and understand a guideline, and then to determine if and when it is applicable to his/her specific clinical case.

Given that treatment guidelines can be expensive and time consuming to develop, disseminate, and implement, it is helpful to carefully select the areas where treatment guidelines can be most useful.

Treatment guidelines have proven to be effective for several clinical situations:

- § Procedures that can result in significant harm to patients, or diagnoses that may involve such procedures (e.g. wound care)
- § Services that are high risk, in the sense that if the patient does not receive the service, he or she may be at high risk for increased disability or impairment, such as mechanical low back pain
- § High cost procedures, such as amputation and subsequent rehabilitation services
- § Procedures for which significant overuse has been documented (e.g. electromyography)

A critical determinant in selecting a treatment guideline is the extent to which change can be achieved. The probability of achieving change requires that not only can an organization get agreement on a guideline but that it implements it.

Legal Implications

Clinicians may fear that they will increase their risk of adverse malpractice judgements if they engage a care plan contrary to that which may be recommended by a national practice guideline. This is not necessary. According to the Physician Payment Review Commission:

- Development and use of sound treatment guidelines will not increase clinicians' exposure to malpractice liability. In fact, guidelines will probably allow clinicians to reduce existing risks.
- Practices that develop guidelines may expose themselves to tort liability if poorly created guidelines lead to patient injury. One study, however, concluded that this risk is small and can be further reduced by following currently accepted procedures for the development of guidelines.
- Well-designed guidelines and review criteria will decrease the incidence of substandard care and will help courts more accurately judge whether a clinician was negligent. They also help patients and their attorneys to determine whether they have grounds for a malpractice suit.

The legal implications of the use of treatment guidelines are still unclear, but it is clear that in the early

stages the benefits of treatment guidelines outweigh the legal risks cited by many clinicians. Strategies for minimizing liability have been put forth by the Agency for Health Care Policy and Research, as well as by the Institute of Medicine. The authors encourage the reader to contact these organizations or the discipline-specific professional association for more information if they are concerned about the legalities of using treatment guidelines.

Developing Guidelines

The length of time required to complete the development of treatment guidelines can range from two months to two years. It depends on a number of factors, including management style, interdepartmental cooperation and commitment to guideline development, as well as the complexity of the guideline. Compared to medical guidelines, many rehabilitation treatment guidelines are relatively uncomplicated and can be developed more quickly. The complexity refers to the degree of certainty surrounding the area under consideration, the level of detail required, and the extent of change required to implement the guideline. More important than the time to produce the guideline is the time taken to achieve true consensus among the clinicians designing and using the guideline. Consensus does not mean that everyone is uniformly enamored with the guideline, only that they are able to comfortably utilize it. The extent to which consensus can be achieved usually depends on the level of supporting information on a subject. If there is a high level of supporting information on a topic, the probability is high that a group will achieve agreement.

A treatment guideline is rarely developed from scratch. There are many good guidelines available today that serve to start the development process. Many times the development process is more of a checking and refinement procedure rather than one of creation. Clinicians often find that national guidelines can be adaptable to the local setting. The critical element in development is active and wide spread clinician involvement, especially by those who are ultimately expected to put the guideline into practice. It has been suggested that clinicians will look skeptically at treatment guidelines developed by entities (e.g. managed care organizations) rather than by their peers.

The literature supports using several principles to guide the development of treatment guidelines :

- § The guidelines should be scientifically, not intuitively based
- § Empiric evidence from credible sources should be sought, evaluated, and incorporated into the guidelines
- § Decisions about the final guideline should be consensus-based
- § The guidelines should be descriptive, not prescriptive
- § The guidelines should be dynamic, not static - they should be pilot tested before dissemination and then continuously evaluated.
- § The guidelines should be widely disseminated and accompanied by education
- § The guidelines should be practical and easily implemented
- § There should be multi disciplinary and wide-spread involvement in the development process - all major stakeholders should be involved as a guideline is developed
- § A guideline should be adapted to suit the purpose or setting in which it will be used. It is important that any local adaptation does not alter the science-based findings, but rather increases its utility in the setting and for the purposes of the user.

Clinician Buy-In

Critical to the success of treatment guideline implementation is clinician involvement and buy-in. This involvement starts immediately when the diagnostic categories for treatment guidelines are selected. The selection process has to be perceived by clinicians as legitimate.

A key challenge to those involved in the development of treatment guidelines is ensuring that the process selected is sound and objective, that it facilitates the development of guidelines based on scientific evidence, not personal views.

One research group, in conducting a study about clinician attitudes towards computerized treatment guidelines, found that clinicians are willing to use clinical guidelines under the following conditions:

- \$ They are not totally prescriptive, allowing for deviation when appropriate.
- \$ They are easy to incorporate into their daily routine of administering patient care.
- \$ They do not significantly increase the workload for themselves or their office staff
- \$ They improve patient outcomes, including patient satisfaction
- \$ They reduce overall cost of care
- \$ They decrease the "bureaucracy" of working with managed care authorization and administrative processes.

These statements can serve as guiding principles for rehabilitation treatment guideline development as well as ensuring that the ultimate product is one that will gain the support of practitioners.

Treatment guidelines are now being implemented in all aspects of rehabilitation care. Soon it will be rare to find a rehabilitation practice that is not using treatment guidelines of some sort. Eventually, they will establish regional and national standards of practice.

Utilization Management in Managed Care

Programs to manage health care utilization have existed for more than twenty years. Early efforts focused on reducing the number of expensive hospital admissions and reducing unnecessary hospital days. To achieve this objective, health plan administrators reviewed the hospital admission for clinical necessity prior to the admission (precertification) and determined the need for ongoing care (concurrent review). For cases that were not part of initial review, a retrospective review was used. These same procedures are now aggressively being applied to rehabilitation services.

It is common that provider or payer sponsored utilization management program includes preadmission and concurrent review. Typical characteristics of these two components are:

- \$ Collection of data about diagnosis, required services, symptoms and prognosis
- \$ Review of criteria that describe the conditions or services to support the care request
- \$ Comparison of clinical information to clinical necessity criteria
- \$ Referral of case to internal or external review if specific criteria are not met
- \$ Final determination of clinical necessity
- \$ Communication of review outcome
- \$ Right of clinician to appeal decision

It is critical to note that utilization management should be most aggressively pursued by that party - either the MCO or the rehabilitation practice - that carries the most significant financial risk.

Because of the importance of utilization management procedures, state legislatures and accreditation agencies have developed standards. In many states, failure to adhere to these standards means that the insurer or utilization review organization could not perform precertification or utilization review. Many external insurers and utilization review companies rushed to become certified. The standards require external utilization management programs to:

- § Limit the information collected to the review being performed
- § Promote timely decision making
- § Notify parties of outcome decisions
- § Use explicit criteria to determine clinical necessity
- § Provide a mechanism to appeal review decisions
- § Promote the use of appropriately credentialed staff for review activities

As the national market penetration of managed care has increased, the precertification and concurrent review processes continue to evolve. Initially, insurance companies or their contracted utilization review companies conducted these activities. More recently, provider organizations and inpatient facilities participating in risk contracts have developed the mechanisms to conduct precertification and concurrent review. The scope of services that precertification and concurrent review apply to has expanded to include outpatient services and freestanding ambulatory surgery centers. Standards for the decision making process have been developed by the Utilization Review Accreditation Commission (URAC) and the National Committee on Quality Assurance (NCQA).

Although precertification and concurrent review are the oldest and most developed processes for containing utilization, their impact on utilization is unclear. Supporters of these processes suggest that they have hastened the development of outpatient technology, encouraged the shift from inpatient to outpatient care, reduced the number of unnecessary inpatient days and helped the timely identification of patients who require discharge planning and case management.

The need to manage utilization continues to exist but health plans and providers recognize that alternative and more effective programs need to be developed. Techniques such as clinical pathways and disease management are additional approaches to managing utilization. These two techniques provide information about optimal treatment methods for certain disease conditions, and prescribe treatment methods and visit frequency.

Precertification and concurrent review remain as the mainstay of many utilization management programs.

For those rehabilitation organizations who are at significant financial risk and who are planning to conduct precertification and concurrent review, the following activities are recommended:

- § Emphasize precertification and concurrent review processes. The processes should focus on those cases that are high volume, pose significant risk of overutilization, and/or for which there are not clear indications for care. Limiting the number of procedures or services subjected to precertification enhances the cost benefit of the review process by reducing administrative overhead. Clinicians who have demonstrated competence in managing cases may even be considered for exemption.
- § Focus on efficiency and personal interaction. For routine cases, where complete information is provided, the case can be certified via telephone call or fax. If the case is unable to be immediately certified, the process for completing review should be timely.
- § Develop strategies to provide support for clinicians. Using a senior clinician to determine the need for rehabilitation care, manage ongoing care and coordinate care among multiple disciplines is gaining increasing popularity. The development and implementation of guidelines and critical pathways will also provide assistance to primary care providers.
- § Coordinate precertification and concurrent review with other clinical management programs. The value of precertification and concurrent review can be enhanced by using the results of these processes to support other activities. For example, precertification activity can also trigger the case management process. Concurrent review can supply data about quality indicators and determine if cases pass quality screens.
- § Focus on questionable practices.
- § Implement an explicit process for managing denials and appeals and internal disagreement.

Referral Management

"Referral management" is often the most onerous of all managed care processes for both providers and for members. It is often perceived as a bureaucratic, paper-shuffling exercise, which pits the referring physician, the clinician, the rehabilitation practice, the member, and the member's family against the "Insurance Company."

Referral management is the process by which referrers determine if they need to refer a member either to a specialist or for services to be performed outside the Primary Care Physician's office (diagnostic tests, rehabilitation therapy, outpatient surgery, home health care, etc.). If a referral is necessary, the referrer also needs to decide to whom the referral is made, for how long, and for what services. In an exclusive provider arrangement or a capitated agreement, there is little choice of where the patient goes, only if they go to therapy.

Referral Guidelines

Many rehabilitation practices have developed their own suggested referral guidelines, sometimes in cooperation with their usual referrers. These guidelines are for common rehabilitation procedures and diagnoses and describe the tests and/or treatments a referrer should perform prior to referring a member to rehabilitation therapy. Everyone in a capitated environment (both physicians and rehabilitation providers) should have incentives to ensure that the rehabilitation clinicians focus their time only on appropriate referrals, thus guaranteeing minimal overhead and adequate access for capitated members. If the rehabilitation provider is also capitated, then they should insist on implementing referral guidelines. There are also proprietary referral guidelines, such as those developed by Milliman and Robertson, an

actuarial company which has developed managed care guidelines for acute inpatient hospitalizations, skilled nursing stays, and home health care, as well as primary care and several other clinical areas. Milliman and Robertson referral guidelines are consensus-based, literature-driven protocols, developed, refined and tested by clinicians from all over the country, and are purchased and utilized by many health plans and medical groups. Referral guidelines can be viewed as educational checklists for the referrer - to ensure that the most appropriate referral occurs.

Problems with Guidelines

If all potential referrers would utilize the same referral guidelines, there would be no need to "manage" the referral process. The referrers would themselves be doing the managing. This consensus would eliminate the need for any additional oversight of referrals. However, many referrers do not want to utilize guidelines. Referrers do not want to be seen as a rationing agent by their patients. If a patient demands a referral to rehabilitation, but the referral is not clinically indicated, some referrers want the rehabilitation provider or the "Insurance Company" to be the one to deny the request. These referrers may feel that by refusing patients' requests, they run the risk of destroying their clinician-patient relationships. This is also a problem when the referrer believes that a certain treatment or therapy is clinically indicated, but it is not a covered benefit. In these cases, the rehabilitation provider can end up managing inappropriate (not meeting guidelines) or non-covered referral requests.

The current micro management of the referral process is an indication that efficient referral systems are not yet widely in place either for the Managed Care Organization or the rehabilitation provider. Until they are, patient complaints about these processes have created the growth of new insurance products and variations such as point of service plans. Whether the rehabilitation practice is trying to encourage or limit utilization is likely to depend on the financial incentives and risk in place in their provider contracts. When the rehabilitation provider is at risk, it is likely that many of the systems previously used by Managed Care Organization to constrain rehabilitation referrals and utilization will actually be initiated and implemented by the rehabilitation provider, not the Managed Care Organization.

Quality Management

Is quality and managed care an oxymoron? Absolutely not, but there are some who doubt the emphasis managed care organizations place on quality care and service. Managed care, often seen primarily as a cost cutting initiative struggles to prove to the community at large that managing quality is as important as managing costs. Some clinicians and managers fear that the goal of managing care is being replaced by the goal of managing costs. Remember that for-profit managed care organizations (and for-profit health care providers) have a legal and fiduciary responsibility to put stockholders, not providers or consumers first.

Trends that shift the financial risk to providers through capitation or other systems that reward providers for efficiency will also give providers a financial incentive to withhold care, necessary or not. Regulators, accrediting bodies, employers and consumers alike are placing increasing demands on managed care organizations and clinical providers to unequivocally address quality.

Definitions

Quality Assurance (QA) is a systematic, departmental approach to ensuring a specified standard or level of care. Traditionally, it has focused on detecting and solving "special" problems. It uses methods to inspect performance, and repair or correct performance. The emphasis has been on identifying errors and problems and working to correct them.

Quality Improvement (QI) is a systematic, organization-wide approach for improving the overall quality of care. It emphasizes performance improvement as well as a standard of care. It differs from QA in its scope, focus, approach and end result. The scope is organization-wide rather than department specific. The focus is on identifying common causes and on processes, rather than on problems or clinical outcomes. The approach is proactive rather than reactive. The goal is to prevent errors and to improve rather than to inspect, repair problems and comply to standards.

Quality Management (QM) is an all encompassing philosophy that is present throughout an organization's management infrastructure, policies and practices. It typically consists of five basic principles -- a focus on customer/supplier relationships; an emphasis on operational and care systems and the prevention of errors; the use of data-driven decision making; the active involvement of leaders and empowerment of employees; and, an emphasis on continuously improving performance in all areas. QM includes features of both QA and QI but goes one step further to define a management philosophy. Not only do these definitions differentiate the three quality terms, they also detail the evolution of the quality movement in managed care from QA to QI to QM. Today, all managed care organizations, and the providers working with them, employ QA, most have adopted QI, and some have evolved to QM.

Incentives for Quality in Managed Care

There are many forces driving rehabilitation practices toward managing the quality of care and service they provide. Each of these drivers has an impact on the quality of care and services provided, but together, their impact has been significant. Rehabilitation providers have evolved from employing traditional QA mechanisms to adopting the broader focus of QI. Some are going even further to implement QM activities. No practice can maintain the status quo. You are expected to build upon and improve performance yearly.

One group of researchers have described activities that are driving the quality evolution in a managed care environment:

- § **State Oversight** The states regulate Health Maintenance Organizations (HMOs) and other forms of managed care usually through their department of insurance. While the states look at a variety of variables such as enrollment and utilization review, they are also interested in quality. Most states ask Health Maintenance Organizations to have specific QA plans and to take corrective action when problems are noted. The National Association of Insurance Commissioners has developed model statutes to be used by the states to ensure access and quality of care in Managed Care Organizations. The statutes move managed care from QA to QI activities and have been developed with the input of insurers and consumers.
- § **Federal Oversight** The U.S. Department of Health and Human Services (HHS) also has the responsibility for overseeing federally qualified Health Maintenance Organizations and those plans enrolling Medicaid or Medicare enrollees. Outlined in federal statute are a comprehensive set of benefits that Health Maintenance Organizations must provide, as well as specific requirements for the Health Maintenance Organization, including reporting on utilization patterns, availability, and

- accessibility. For Medicaid managed care plans, Health Care Financing Administration (HCFA) has established additional requirements including written QM programs that must be part of any contract with Managed Care Organizations. Compliance with the QA program, which usually entails independent external quality reviews, requires focused studies on clinical care and delivery systems as well as an examination of both under- and over utilization. HCFA also has similar requirements for Medicare risk bearing plans to ensure financial solvency, quality, and access.
- § **Voluntary Accreditation** Most managed care organizations are not required to obtain accreditation. Competition from other Managed Care Organizations who are accredited is forcing pursuit of accreditation. In the area of voluntary accreditation, there are three primary drivers -- The National Committee on Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Utilization Review Accreditation Commission (URAC).
- § **Employer and Business Mandates** In an environment lacking in strong quality information, employers have evaluated health plans based on costs alone. Large employers are moving away from evaluations based on costs alone to evaluations that include financial efficiency and quality components. Employers want to ensure that they are receiving value for their health care dollar. Standard performance indicators such as the Health Plan Employer Data and Information Set (HEDIS) enable employers to compare health plans in meaningful ways. Employees are better educated about quality health care and are asking employers about quality. Employer groups are hiring benefits managers with clinical backgrounds when they recognize the relationship between effective clinical management and low claims costs.

Rehabilitation providers compete for business not only on costs, but on the quality of care and service that they provide. Those that have failed to pay attention to the importance of quality, are quickly discovering that quality needs to gain a greater importance within their organization if they are to remain solvent over time. Providers that cannot prove their effectiveness through performance indicators, will find themselves scrambling to catch up. Rehabilitation providers must be able to prove their value to purchasers of health care and have documented quality programs in existence.

Characteristics of a Successful Quality Program

A successful quality program has the following characteristics:

- § Clear Mission and Goals.
- § Active leadership.
- § Defined Structure & Accountability.
- § Coordinated Activities.
- § Effective Planning.
- § Comprehensive Scope of Services.
- § Focus on Improvement.
- § Data Driven Decision Making.
- § Sound Policies & Procedures.
- § Adequate Resources.

Your job as a rehabilitation clinician and manager is to use the tools of quality management in a managed care environment to provide the best service to those you serve as cost effectively as possible.

Credentialing in Managed Care

The National Committee for Quality Assurance (NCQA) sets standards for credentialing in managed care.

Credentialing is defined as the "process by which a managed care organization authorizes, contracts with, or employs practitioners who are licensed to practice independently to provide services to its members". Credentialing focusing on ensuring that a practitioner is qualified to render care. Each managed care organization sets its own qualifications and then structures its processes to ensure that the practitioners meet these qualifications. As a provider, your internal systems will need to mirror those of the Managed Care Organizations you contract with.

This section focuses primarily on the credentialing of physicians within the managed care environment, but it also briefly addresses the credentialing of non-physician practitioners, such as therapists. The information is based on relevant NCQA standards and industry norms; however, it is not intended to replace those publications produced by the NCQA.

Clinician Requirements

Each managed care organization (MCO) is responsible for establishing the criteria for participation within the health plan, based on the needs of the members and the standards of the Managed Care Organization. While there is bound to be some variation on the specific criteria, the basic elements for a clinician are likely to include the following:

- \$ Valid and current licensure
- \$ Clinical privileges at a hospital (when appropriate)
- \$ Valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate (when appropriate)
- \$ Appropriate education & training - i.e., graduation from an approved clinical school and completion of an appropriate residency or specialty program.
- \$ Board certification (if specified by the practitioner or required by the Managed Care Organization)
- \$ Appropriate work history
- \$ Malpractice insurance
- \$ History of liability claims

The Managed Care Organization must establish a system that ensures practitioners meet these standards. This system or process is commonly referred to as credentialing.

Non-Physician and Provider Requirements

Managed Care Organizations are responsible for credentialing all independent practitioners with whom they contract, or employ, including physicians, therapists, nurses, dentists, chiropractors, podiatrists and rehabilitation professionals. The Managed Care Organization is not required to credential practitioners who practice exclusively within another organization, such as the inpatient hospital setting, or free standing facilities like mammography centers, urgent care centers, or surgicenters because they are under contract with that organization and have no independent relationship with the Managed Care Organization.

Non-physician practitioners undergo a credentialing process much like that of physicians. The differences lies in the requirements and therefore in the verification of select data. For example, physical therapists are not board certified and do not require DEA or CDS certificates.

As for credentialing organizational providers, the Managed Care Organization is to have policies and procedures that speak to the initial and ongoing assessment of organizational providers with whom it intends to contract, including hospitals, rehabilitation centers, home health agencies, skilled nursing facilities, nursing homes, and free-standing surgical centers. As a provider within the Managed Care Organization, it will be necessary to understand and comply with these policies and procedures. The Managed Care Organization is expected to confirm that the provider is in good standing with state and

federal regulatory bodies, and has been reviewed and approved by an accrediting body. If the provider has not been approved by an accrediting body, the Managed Care Organization must develop and implement standards of participation. Finally, the Managed Care Organization must "re-credential" the provider at least every two years by confirming that it continues to be in good standing with state and federal regulatory bodies and the appropriate accrediting body.

The Credentialing Process

The credentialing process consists of a series of activities leading to a decision to accept or reject an individual's application as a health care provider. Specific activities may vary by location and clinical discipline, but there are activities common to most credentialing processes. Frequently, the credentialing process is outlined in the organization's bylaws. A sample credentialing process is outlined below:

- § **Application.** Each applicant completes an application (credentialing) form, including a signed release granting the Managed Care Organization access to key information. Each application is accompanied by a copy of the applicant's current, professional license, current, DEA registration if applicable, and the face sheet of the applicant's current professional liability insurance policy. The application for membership also includes a statement by the applicant regarding ability to perform essential functions of the position.
- § **Initial Screening.** The application is reviewed for completeness. The Chief Medical Officer (CMO) of the Managed Care Organization or practice reviews the application to determine if a preliminary interview is warranted, and if the full credentialing process is to be initiated.
- § **New Provider Site Visit --** The applicant is notified that a new provider facility assessment and clinical record keeping process audit must take place. This is conducted during the time of primary verification of credentials. The site visit includes an assessment of a number of criteria for which the Managed Care Organization has set out acceptable performance standards including physical accessibility, physical appearance, adequacy of waiting and examining room space, availability of appointments, adequacy of medical record keeping, and quality of care.
- § **Primary Source Verification --** There are seven criteria must be verified from the primary source because they define the legal authority to practice as well as the relevant training and experience. Managed Care Organizations may choose to use an external agency to collect information from the primary sources. If this is the case, the Managed Care Organization has delegated this component of the credentialing process and must assume oversight functions. The criteria that require primary source verification include:
 - Valid license to practice.
 - Status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility.
 - Valid DEA or CES certificate, if applicable.
 - Education and training of practitioners - graduation from clinical school and completion of a residency.
 - Board certification if the practitioner states on the application that he/she is board certified.
 - Current adequate malpractice insurance according to the managed care organization's policy.
 - History of professional liability claims that resulted in settlements or judgements paid by or on behalf of the practitioner.

- **Credentialing Committee.** After all required data elements have been received, the individual practitioner's credentialing file is entered into the Managed Care Organizations credentialing database and readied for presentation to a Credentialing Committee. The database assists in tracking an application's stage in the process and further assists in ensuring appropriate review of time-sensitive material (e.g. license, DEA certificate, etc.)
- **The Decision.** The decision to accept or reject an individual's application is made by a Credentialing Committee comprised of a range of participating practitioners who are capable of bringing technical knowledge and current clinical practices to the table. The Committee reviews the files of all applicants who do not meet the Managed Care Organization's basic qualifications, and they should review the list and select files of applicants who do meet basic qualifications.
- **Recredentialing.** A re-credentialing date is set for no more than two years after the initial credentialing decision.

Delegated Credentialing

Managed Care Organizations and rehabilitation practices can and do delegate all or some aspects of the credentialing process to outside organizations. While it is acceptable to delegate credentialing activities, this does not transfer responsibility. Even with delegation, the Managed Care Organization or rehabilitation practice retains the right to approve or reject individual practitioners based on quality of care issues. There must be annual evaluation of the delegated agency to determine whether the contract should be renewed. Credentialing is a critical first step in assuring qualified practitioners render and manage the care of rehabilitation patients. Failing to devote sufficient attention and resources to credentialing runs the risk of providing substandard care.

Accountability Management in Managed Care

From the beginning, rehabilitation providers have been held accountable to multiple masters: purchasers, regulators, consumers, and the community at large. Each has a vested and unique interest in making the provider answerable for the care and service it provides. This accountability has become increasingly difficult as care has become more complex. This section focuses on the accountability mechanisms often in place to oversee the quality and utilization activities of a typical Managed Care Organization or rehabilitation practice.

Accountability Framework

Managed care accountability mechanisms can be conceptualized as falling within four categories.

- § Self regulation has been very evident from the beginning of the managed care era. Included here are the regulation of the health practitioners themselves, the use of contracts to regulate the providers that ultimately provide the care, and accreditation programs. Self-policing activities were once considered adequate, but have been supplemented by more stringent demands in recent years.
- § External Regulation at the Federal and State Government level. The number of Medicare and Medicaid beneficiaries enrolled in managed care plans has experienced unprecedented growth. HCFA and many state government agencies are taking steps to protect its beneficiaries through regulations and enforcement activities.
- § The Legal System. Accountability for quality can often come from civil verdicts where liability for damages from poor clinical outcome lawsuits has had a dramatic effect on the behavior of the industry.

§ Marketplace Demands. The marketplace has begun to collectively examine more closely the inner workings of managed care. Much of the interest has been stimulated by exposes printed in the popular press and much of the marketplace efforts have focused on measuring the performance of health plans across a variety of dimensions.

Accountability Mechanisms in Managed Care

Provider Contracts

Managed Care Organizations rely heavily on their networks of providers to be accountable for the care and service they provide. They have developed elaborate provider contracts that stipulate

- the criteria to be used for appointing and credentialing practitioners,
- cause for terminating practitioners who do not meet "quality" standards,
- adherence to the plan's quality improvement efforts, and
- use of clinical treatment guidelines and standard medical record keeping systems.

These are some of the clauses that can be found in provider contracts. Recently, the Managed Care Organizations have put more emphasis on these contracts and are more conscientious in using them for accountability purposes.

Accreditation

Accreditation has been used, at times, to differentiate qualified performers from those who are not.

Federal Accountability

The U.S. Department of Health and Human Services has the responsibility for overseeing specific Managed Care Organizations including federally qualified Health Maintenance Organizations and those plans enrolling Medicaid or Medicare enrollees. Outlined in federal statute is a set of benefits that Health Maintenance Organizations must provide and specific requirements, including reporting on utilization patterns, availability, and accessibility. In Medicaid managed care arrangements, Health Care Financing Administration (HCFA) has established additional requirements, such as formal written Quality Management programs that must be part of any contract.

The primary oversight mechanism outside of regulations, is that of the Peer Review Organizations (PROs). The PROs are groups of practicing clinicians paid by the federal government to monitor the care given to Medicare patients. Each state has a PRO that decides whether care given to Medicare patients is reasonable, necessary, and provided in the most appropriate setting. PROs also must decide whether care meets the standards of quality generally accepted by the clinical profession. Providers serving the Medicare population are required to cooperate with PROs as a condition of participation in Medicare.

State Accountability

Most states regulate Health Maintenance Organizations and other forms of managed care through their department of insurance or department of health. State control of managed care usually:

- § Prohibits Health Maintenance Organizations from issuing any materials which are false, misleading, or deceptive,
- § Requires adequate access to personnel and health care facilities.
- § Requires plans to have specific quality assurance plans, and to take corrective action when problems are found.

- § Mandates that Health Maintenance Organizations have specific grievance procedures.
- § Requires plans to collect, analyze, and report to the state certain utilization, enrollment, and grievance data.
- § Mandate that certain information be provided to enrollees and the public at large, including the enrollee's financial obligations, covered and excluded services, and how to obtain services and file a complaint.
- § Requires mechanisms to solicit enrollee participation in Health Maintenance Organization policy decisions.
- § Requires a system to ensure the Health Maintenance Organizations financial solvency and to hold the enrollee harmless for a carrier's failure to pay the provider.
- § Includes a variety of enforcement mechanisms to ensure that Health Maintenance Organizations compliance.

The appendix lists the contacts and addresses for the insurance department or health department in each state. The National Association of Insurance Commissioners (NAIC) recently developed model statutes for managed care organizations. The statutes cover quality assessment and improvement, provider credentialing, utilization review, provider network adequacy and contracting, and grievance procedures. These model statutes should facilitate consistency across state lines and ensure a minimum set of oversight expectations for Managed Care Organizations. States have introduced a record number of bills to regulate managed care. Many states have enacted maternity length-of-stay statutes, and others have bills awaiting governor's signatures. Many states have enacted emergency service laws and some have enacted patient protection provisions.

The Legal System

There is currently a trend toward holding Managed Care Organizations legally responsible for the care they provide to patients. More and more legal cases have held that because of the direct relationship between the Managed Care Organization and the individual's health care provider who caused harm to the patient, the Managed Care Organization should be held liable.

Marketplace Demands: Performance Measures

Purchasers have begun to ask for a mechanism to measure Managed Care Organization performance in terms that facilitate comparisons across health plans. NCQA's Health Plan Employer Data and Information Set is known as HEDIS. HEDIS 3.0 establishes a standard as a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. HEDIS measures performance in eight areas: effectiveness of care, access/availability of care, satisfaction with the experience of care, health plan stability, use of services, cost of care, informed health care choices, and health plan descriptive information.

When compared with statutes and regulations, public disclosure of key information may be an effective means of consumer protection in managed care. Purchasers and consumers should continue to demand performance measurement systems that help them make informed health plan decisions. This trend toward reported performance measurement is also being expanded to include individual providers. It is imperative that clinicians and clinical managers participate in developing tools that accurately inform the public of key information. With the complexities involved in collecting and analyzing health care data from multiple providers, scientific methods must be utilized. It is the only way to assure that health care data and outcomes are not misused or misleading.

Implications for physical rehabilitation

To function effectively in a managed care environment, it will be necessary for rehabilitation managers and clinicians to become familiar with the personnel and operations of managed care organizations. This will include utilization managers and utilization management, outcomes management, and clinical guidelines.

Summary

This chapter has examined the clinical strategies needed in a managed care environment. We will next examine the management strategies that must accompany them.

Management Strategies for Rehabilitation in Managed Care

Overview

This chapter will examine key factors in managing a rehabilitation service in a managed care environment. We will initially review various aspects of moving into a managed care contract, including how to decide if you are ready to proceed with negotiations. We will also examine whether being involved in a managed care contract must necessarily change the specific care that is provided. A significant portion of this chapter is devoted to capitation and other risk sharing concepts because of the radical manner in which these arrangements change the entire incentive structure of health care reimbursement. We will also discuss the critical aspects of interacting with managed care organizations in a professional and successful manner. Last, we will examine the typical managerial functions of planning, strategic planning, budgeting, selecting, recruitment and retention, structuring, and supporting. The impact that managed care may have on individual managerial style will also be considered.

Preview of Major Topics

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How to Negotiate a Managed Care Contract

Managed Care Contracting

Preparing for Managed Care Contracting

Key Factors Before Negotiations Begin

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Summary

Financial Strategies

How to Negotiate a Managed Care Contract

Negotiating a managed care contract can be a very complex process. There is a significant amount of background information to become familiar with. This section will examine the basics of working with the Managed Care Organization to develop a contract that will be successful for both parties. The emphasis will be on the content, not the process of the negotiations. For the reader interested in more information on the skill of negotiation, Kovacek Management Services, Inc. offers onsite negotiation workshops and training materials.

Managed Care Contracting

Managed Care contracts come in many varieties. However, there is standard contract language that remains fairly consistent throughout the industry. Standard language can be state-mandated to protect the insured, be required by an employer, or be market driven. As a provider, you should understand how these requirements are similar and how they differ. It is important to know when you should consult a lawyer or your malpractice carrier, or when standard language means non-modifiable, ie, you would waste your time and money on a lawyer because a large number of previous rehabilitation providers have been unable to negotiate these terms and have signed the agreement as is. Each managed care organization has a number of standard "boilerplate" agreements it uses for the different types of rehabilitation providers or groups, each with varying payment arrangements.

Preparing for Managed Care Contracting

The concept for contracting for services in health care is not a new one. The need of having a written agreement though has taken on greater importance in recent years. Because of the complexity of today's business relations, new government regulations, accreditation requirements, demands for quality medical care and the assumption of additional risk by the provider community, having a written agreement between the parties is essential. And that agreement goes both ways. While most providers believe that contracts provide greater protection to the insurer, it is clear by these examples that they can benefit providers as well. At the same time, a growing trend in which insurers are using the specter of government regulations and accreditation requirements to try to effect changes to contracts is of concern.

It is incumbent upon all parties to understand their rights and obligations in a negotiation. Because of the complexity of the current arrangements being negotiated, it is important that a team of experts be assembled to ensure that the rights of all parties are protected. As managed care becomes a greater component of a provider organization's overall revenue base, the importance of the written agreement grows along with it.

In the past, many agreements in the managed care field between providers and insurers were still on a handshake basis and many of the few that were written contained very little in the way of specific performance requirements. Often these agreements were no more than four or five pages in length. Those contracts that were more complete usually involved agreements between groups and insurers for the provision of capitated services. Recently however, there have been changes in government regulations, accreditation requirements, complexity of reimbursement, and other issues which have pushed even the simplest of agreements to twenty pages or more, depending on the type size. Many insurers, trying to cover all of their bases, have written contracts that incorporate all lines of their business, even though the provider is only looking to cover a certain portion of the insurer's population. In the case of preferred provider agreements, the insurer has added language that allows it to "sell its network" to a variety of entities. This can lead to surprises for the provider who, expecting a certain reimbursement rate

for a patient carrying that insurer's card, finds instead that a significant discount has been taken because that patient is covered under an agreement of which the provider was not fully aware. The proliferation of these so called "Silent PPO" agreements has caused great alarm in the provider community. Usually, a provider organization is willing to enter into an agreement to provide services when it has some reason to believe that in return for giving the insurer a preferential rate, it will receive a certain volume of patients or provide certain services. The "silent PPO" agreement puts the provider in the position of giving a discount to the insurer whether one patient receives services or not. Any businessperson will tell you that this is a highly unusual way to do business.

Key Factors Before Negotiations Begin

There are two key factors for you as a provider to consider before entering into a written agreement with a managed care organization. Managed care organization may include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) or other entity that sells a product that may limit member access and/or create a reimbursement model that includes the provider in the risk. The first is the environment in which you are practicing, which can vary even within the same community. What may be good for primary care providers may not be as advantageous for specialists, institutions, or ancillary service organizations. You will probably want to start by asking yourself (and others) a few questions about market penetration, gross premiums, and market

composition as you consider the necessity of entering into one or more arrangements.

- \$ Is your market in an early stage of managed care or has it fully matured?
- \$ Is there one dominant payer? Or is the market divided among a number of insurers?
- \$ Are your competitors signing up with everybody, or are they being selective?
- \$ Is one insurer willing to pay a premium for exclusivity?

While the list of questions goes on, it becomes apparent that the decision is complex and takes a significant

amount of information in order to make an informed business decision. The second key issue in determining whether to contract with a particular managed care company is the terms and conditions of participation. Again, the questions seem endless. Among others:

- \$ How much risk must you accept?
- \$ Is the fee schedule within community standards? Where do you find community standard information?
- \$ If you are negotiating a per diem, is there a stop loss provision (and does it work to your advantage)?
- \$ As a rehabilitation provider under a capitation arrangement, can you be assured of receiving a timely and accurate enrollment and eligibility report?
- \$ Is there a mechanism to control excessive or inadequate referrals from participating physicians?
- \$ What is the division of responsibilities?
- \$ Are there any incentives for you the provider? If so, what are they?
- \$ Are there incentives for other providers that may affect your contract?
- \$ What are the requirements for terminating the contract (for both you and the managed care organization)?
- \$ What are your rights if the insurer changes benefits?
- \$ Is there a requirement that you sign an amendment, or does the fact that you do not object in writing suffice to signal your acceptance?
- \$ What sort of notice is required and what is the time frame? If you choose to alter the contract or

- you choose to end the relationship are you precluded for any period of time from retaining the patients under a different arrangement?
- § Are there any geographic non-compete clauses? After termination of the contract, are you restricted from providing service within the same geographical areas as the managed care organization with whom you had the contract?

Getting Started

You may also want to ask the following questions, as the answers will assist you in your review of the proposed contract:

- § How many other providers have signed this particular agreement?
- § Are they willing to be used as references?
- § Which sections of the contract have been modified over time? (The plan may or may not agree to share this information).
- § Has this contract been reviewed by the state's largest malpractice carrier? Request a copy of those comments.

Review of the contract begins with the basics. Remember, the contract was developed by and for the managed care organization: The purpose of the language is to give the Managed Care Organization the most favorable terms. The following is a sampling of the most important sections that may be present in managed care organization (MCO) agreements that you are offered:

- § **Review of the Parties.** This area defines the players, the rehabilitation provider and the insurer.
- § **Services Provided.** Services must complement the covered services under the agreement. If a plan chooses or is required by the state to add benefits, they typically give a provider 90 days written notice. You may have the right to terminate if you cannot or will not agree to perform the service. Generally, the addition of more benefit coverage is of concern when a group is operating under a risk contract. Compensation for increased benefits should be adjusted in a manner acceptable to you.
- § **Location of Services.** It is important to include complete addresses to ensure accurate marketing of services. You will often only be able to provide services at the location listed. Be sure to understand how to handle additional locations.
- § **Policy and Procedures.** Policy and procedure manuals are referenced in most contracts. Review all manuals before you sign an agreement promising to follow them. Most organizations are unable to keep their manuals as current they would like due to the rapid growth of the industry, and because they are often required to review and make change to their processes by employer groups. Ask for all appendices to the manual. Also, provider groups should include language in their contracts to the effect that revisions to the manual should be provided with at least 30 days advance notice, with allowance for a recourse if they do not agree with the terms.
- § **Credentialing Standards.** With agencies such as HCFA, state insurance agencies, and the like, demanding more stringent assurances of quality, managed care organizations have begun to utilize the strict guidelines for credentialing rehabilitation provider networks that were created by NCQA (National Committee for Quality Assurance). It is vital that you understand the procedures and processes for credentialing and renewal, as they are time consuming for you and your office staff. Look into obtaining a standard format established by NCQA, keep copies in your office, and train your staff to have them readily available. Chapter 5 has much more information on the credentialing process.
- § **Medical Records.** The requirement that providers maintain and retain medical records is standard medical practice. Each state has regulations regarding the length of time records should

be kept, 6-10 years in some cases. By state regulation, Managed Care Organizations must have access to all medical records as they pertain to the members' medical service while covered. Rehabilitation providers are required to cooperate with a plan to report potential patient fraud, member acts of omission committed during enrollment, information relating to change or loss of employment, third party liability and/or workers' compensation. Clinicians are asked to use their best efforts to notify the Managed Care Organization under these circumstances.

§ **No Recourse Against Patient.** A Managed Care Organization often does not allow a provider to bill or collect monies from a member for any covered services, exclusive of co-pays. The patient is protected from any payment dispute between the Plan, the employer groups, and the provider. This clause supersedes any other understanding and survives termination of the agreement.

§ **Liability coverage.** Providers must provide documentation of liability coverage, including comprehensive general and professional liability, and workers' compensation coverage, in amounts customary for the state and as required by the Plan. Any coverage changes must be provided to the Plan in writing 15 -30 days in advance of the change. The provider may also be responsible for notifying the Managed Care Organization of any potential member claim that may arise.

§ **Marketing.** Managed Care Organizations will usually want to use providers' names in their marketing materials, so be sure to review all information provided to each Managed Care Organization for accuracy. Providers are rarely successful in obtaining the right to use a Managed Care Organization's name or logo in any advertisement without permission, so you may wish to negotiate an exchange of permission on this point.

§ **Member grievance.** A Member Grievance Committee established by a Managed Care Organization is typically comprised of plan members and providers. It is organized to resolve patient complaints. These complaints can range from denial of claims or second opinions to provider relationship problems. You should review these resolution procedures carefully, to assure that grievances will be handled to your satisfaction.

§ **Arbitration.** For those times that a provider has an unresolved issue with the Managed Care Organization, it will be important to have included an arbitration clause in the agreement. Arbitration is a formal process for resolving disputes, and is considered the last resort prior to litigation. The losing party in the dispute is usually held responsible for the legal fees of both parties. Managed Care Organizations generally have legal counsel on their staff. If there is litigation, it may cost them little and the rehabilitation provider plenty. It is therefore most favorable to negotiate for each party to pay their own legal fees.

§ **Assignment and delegation.** Managed Care Organizations will wish to have the right to assign the rehabilitation provider contract to any third party should there be an acquisition or merger of the Managed Care Organization. The rehabilitation provider will want written protection against possible material changes in the relationship should such an assignment occur. On the other hand, the Managed Care Organization will not want to allow the rehabilitation provider to assign their Managed Care Organization contract to another party without prior written consent from the Managed Care Organization. This should not be a problem unless the you foresee selling the practice. In that case, this article may be modified to reflect assignment to another party should the party meet all credentialing requirements.

§ **Offset.** A Managed Care Organization may require the rehabilitation provider to agree to an offset provision, whereby it has the right to withhold funds from the rehabilitation provider's check for any reason. However, those reasons should be limited to incorrect or duplicate payments only. There

should also be a time limit such as 90 days for this recourse to be found acceptable to the provider, with the opportunity for the provider to reimburse a duplicate payment without the Managed Care Organization using the offset.

§ **Hold Harmless.** In the past, Health Plans could not be sued for malpractice because the plans performed administrative duties only, and did not practice medicine. This emphasized the independent contractor relationship. However, Managed Care Organizations are implementing controls over medical practice with precertification, second opinion authorization, utilization management and medical necessity decision making. Even with these controls, Managed Care Organizations may require that the provider hold all the medical risk. Notwithstanding these practices, some insurance carriers have recently refused to pay claims due to contractually incurred malpractice liability. They argue that they are insuring the individual medical provider and not the Plan. Prior to signing any hold harmless or indemnification clauses, it is important to discuss the circumstances with your carrier, or ask the Managed Care Organization for written documentation that your carrier has reviewed and approved the contract under consideration. Insurance carriers may have riders covering a rehabilitation provider participating with managed care plans. In addition, you should require equal hold harmless language from the Managed Care Organization.

§ **Effective dates.** Most contracts stipulate that the agreement will not be effective until credentials are approved and both parties have executed the agreement. Make sure the effective date is noted in the contract. This is especially important when you have accepted capitation. Is the effective date the date you agreed to the terms, or is it the date the agreement was executed by all parties and all terms were loaded into the information system of the Managed Care Organization? Don't provide services prior to the effective date unless you have a clear understanding with the Managed Care Organization on how you will be reimbursed for the services.

§ **Rehabilitation Provider Responsibilities.** This section identifies the rehabilitation provider's practice capabilities. Use this section to identify the limitations of your current practice, and any exclusions. For example, if you are an adult orthopedic physical therapy practice, based on current practice patterns you are within your rights to specify such exclusions as children under age two, podiatry services, neurological diagnoses, bone tumors, and other services you consider outside the scope of your practice. Identification of your service capabilities can prevent disputes over the performance of these services in the future.

§ **Payment Arrangement.** Regardless of your method of reimbursement you will need to clearly understand which of the Managed Care Organization members that has been assigned to this payment arrangement and benefit plan. Review, as appropriate, attached fee schedules and compare them to your usual and customary charges. If a Medicare fee schedule is the basis for this payment, obtain a copy of what is being used, as there are different Medicare schedules. Understand that if you accept a Medicare patient through the managed care organization, you may not collect from Medicare. There are also limitations to claims submission. Some plans require claims to be submitted within as little as 30 days, although 90 days is more typical. Payment from the plan is considered payment in full. Understand the policy for the collection of co-payments. Obtain a list of them, and understand your office's responsibility for collection. If a capitation rate has been accepted, determine the level of financial responsibility for services provided by other rehabilitation providers who are covering for you or for emergency services.

§ **Term and Termination.** The term of the agreements is usually for a one-year period, to be

automatically renewed on an annual basis thereafter. Commonly, there is a 90-day out clause by either party with or without cause or reason, which really means that the contract is only a 90-day agreement. This might make you more comfortable, especially when there is a risk arrangement. Recently, the tables have turned. Providers are interested in a more binding agreement so they can count on this patient volume for a long time. When writing their business plan, most providers today need to balance their contracts and payment methods with the many payors. Having substantial segments of your business in one agreement creates considerable risk. Competition can create a bidding war and you may easily lose the contract. Managed Care Organizations can change hospital and physician-referrer affiliations. So, if the contract is valuable to the practice, negotiate for a longer-term agreement, perhaps three to five years. Contracts of this length may be difficult to negotiate due to the uncertainty of a future that far away. Additionally, request termination language requiring cause or reasons (breach) in the contract. Include a requirement where the parties would attempt to work out the dispute over a period of time prior to the termination. Resolution of a dispute is more favorable to both parties than termination of an entire relationship.

Contract Review Check List

- \$ Request a copy of all policy and procedure manuals specified in the contract.
- \$ At a minimum, request that the contract specialist briefly introduce the manuals to your office staff. Ideally, have the Managed Care Organization staff provide training and orientation to your staff.
- \$ Understand the referral authorization procedure.
- \$ Understand the reporting requirements. Obtain samples of the required format for utilization reporting.
- \$ Determine if there are any special requirements, such as the use of specific pre-approval centers.
- \$ Determine what the penalties are when these procedures are not followed.
- \$ Obtain a list of participating physician-referrer, hospitals and rehabilitation providers.
- \$ Obtain a list of the specialty physician network: those on a fee for service basis vs. a capitation rate.
- \$ Request a list of the ancillary providers (home health, skilled nursing, etc.).
- \$ Obtain a contact address and telephone list of pertinent Managed Care Organization staff, including the contract specialist team, utilization management staff, customer service, the provider service representative assigned to your service area, and the Medical Director. These contacts should be easily accessible to the office staff.
- \$ Determine quality assurance requirements: Are you required to participate in any committee functions? By acquiring certain essential skills when reviewing managed care contracts, and choosing the plan participation carefully, a rehabilitation provider can succeed in today's managed care environment. Providers should be sure to ask specifically for contract language that gives them what they want. It is important to remember that any boilerplate contract was written for the Managed Care Organization-it is important that the provider group tailor it so that it become a document that meets the needs of both parties.

Long Term Contracts

Multiple-year contracts may be a desirable alternative because they have the potential to lock in provider market share for a substantial period of time and ensure a predictable income stream. However, such agreements also carry additional financial risk. Before entering into such an agreement, the provider must

consider whether it would be prudent to include additional protection against any future adverse financial situations. To provide the necessary protection, a provider may include an escalator clause that calls for a rate increase at appropriate intervals.

However, if the initial assumptions upon which the contract was based prove inaccurate, for example, if the projections for utilization per 1000 or other cost assumptions are inaccurate, specific provisions, such as escalator clauses, built into the contract may also be inaccurate. As an alternative, or in addition, to an escalator clause, providers may attempt to negotiate risk corridors that provide additional revenue protections. Although payers would prefer that the reimbursement rate remain flat throughout the contract period, this is usually not in the best interest of the provider. Don't settle for less of a deal than you are willing and able to handle.

Moreover, in today's negotiating environment, multiple year arrangements may be difficult to obtain. A Managed Care Organization contemplating major changes, including its own purchase, an acquisition, or a change in a hospital affiliation, may be particularly resistant to such contract language. On the other hand, a multiple year contract may be most appropriate for arrangements in which a Managed Care Organization will obtain significant cost reductions over prior years, and the provider is comfortable with the compensation level. The provider may even have agreed to a gradual reduction in overall reimbursement in exchange for a longer-term arrangement with the Managed Care Organization.

Ending the Managed Care Organization Relationship

Contract termination provisions refer to the abilities of the contract parties to terminate the contract. There are essentially three separate termination types found in contracts: termination without cause, termination with cause, and immediate termination for cause.

Most managed care contracts contain provisions that permit either party to terminate the contract without cause. Commonly either party will have the right to terminate as long as appropriate written notice has been made. This time frame is usually 60 or 90 days. However contracts may allow a 30- day notice or require as long as 120 days. The Managed Care Organization needs a time frame such that, should the contract be terminated, it will have enough time to find an appropriate replacement to meet the needs of its members. Contract termination language should provide both parties sufficient flexibility to protect their business interests.

Careful consideration should be given before signing any agreement that requires a minimum term. A contract may stipulate that the contract will be in force for the initial term before termination without cause may be invoked. Contracts that are limited to termination with cause, even temporarily, may not recognize financial hardship as a valid reason for termination, thus potentially exposing a provider to severe financial losses. This is particularly the case where longer contract terms or required notice periods are in force. Contracts often address a shorter termination period (e.g., upon 10-30 days' notice) in the event that either party has not complied fully with the terms of the agreement. Typically a written notice of breach is required, and the party in breach is allowed a specific period of time (e.g., 10-30 days) to cure the breach before termination is invoked.

The contract cancellation and termination clauses also typically describe situations under which the Managed Care Organization can immediately terminate its contract with a provider. The most common reasons specified for Managed Care Organization right of immediate termination are loss of license, malpractice suit, failure to pay claims, bankruptcy, criminal activity, unresolved and repeated member complaints, failure to maintain insurance coverage as specified in the contract or failure to meet other credentialing requirements. The provider should consider including similar language that describes situations under which it can also immediately terminate the contract.

Terminations for cause should always require a material breach of a contract term. The grounds specifying termination should be specifically spelled out in the contract and clearly worded. A careful review of a contract boilerplate may reveal termination conditions that allow Managed Care Organizations to immediately terminate contracts based on their "sole judgment" of what is in the medical interest of members. These provisions are contract loopholes that will not serve the provider well, and should be carefully considered before being included.

Another termination provision the provider should look for is language which allows the Managed Care Organization to change the nature of the agreement before the contract term is to be renewed. Such provisions allow a Managed Care Organization to terminate the entire agreement if the provider does not agree to the change. Again, from a provider's perspective such a stipulation is best taken out of the contract or significantly restricted.

In addition to the termination for cause examples invoked by Managed Care Organizations, providers should consider as grounds for termination such items as:

- Managed Care Organization failure to produce a minimum number of covered lives.
- Non-payment of amounts due.
- Managed Care Organization change in hospital or referrer-physician affiliation.

How aggressively a particular provider negotiates for such provisions will be dictated by its unique circumstances. For example, in capitation arrangements a decrease in the number of members or a significant increase in a specific type of membership may affect the financial viability of the agreement for the provider. However, insistence on such special provisions will often create a demand for greater flexibility on the part of the Managed Care Organization. Providers must balance their needs according to the strength of their negotiating position with the Managed Care Organization.

What Happens After Termination?

In the event that the agreement is terminated, responsibilities of both provider and Managed Care Organization must be clearly stated in the contract to avoid future disputes. Managed Care Organizations will protect their interests by stipulating in the contract that the provider will be responsible for rendering services to members until the treatment plans are completed or until the Managed Care Organization has made reasonable and medically appropriate provision for the transfer of these patients to a new provider. The contract should also include a period of time in which transfer of patients will occur.

Such provisions are common and should be sure to specify the method of payment for services provided beyond the contract termination date. After termination of the agreement, a typical method for provider reimbursement by the Managed Care Organization is using fee-for-service rates already stated in the contract.

Providers should also have a clear understanding of any obligations they will have even after the termination of an agreement. Some contract provisions will contain language that specifies that the provision survives the termination. For example, provisions that preclude a provider from holding Managed Care Organization members and their employers financially liable for services provided under the contract often include this language. Providers should be mindful of how such provisions may obligate them in the future, or limit their recourse.

Additional Considerations in Contracting

Once you have reached a final agreement with the payer, the difference between success and failure will depend on your knowing how to implement the agreement, making certain that you receive full benefit from the agreement, having an operating system that limits your risk exposure, and paying very careful attention to the details of the contract.

Understanding your environment may seem simple, but the failure to pay attention to the smallest of details could place your organization at significant risk. Understanding the development of the gross premium is an important factor in negotiating and agreement. The gross premium is the amount that the insurer charges an employer per covered life. By understanding this number you can generally break out the different factors and establish a reasonable estimate of what the payer should be willing to reimburse you for the services you provide. There are many adjustments that may be made to that number, but you should be able to determine the general community contract cost. Once you understand the various cost factors, the mystery of how reimbursement is calculated is lessened and setting the gross premium now becomes more of a matter of negotiation than guesswork.

Another area that providers need to concentrate on is the cost of providing the service. Most organizations do not fully understand their costs. Many are willing to accept contracts that barely cover their marginal costs. This may be fine if managed care is only going to be a small part of the revenue base. But if you are entering into a contract that is going to require that you provide greater services or add personnel, you cannot look upon the agreement as filling unused capacity. Again, knowing how the insurer prices his product will assist you in coming to a successful conclusion to your negotiation. The intersection of your costs and the insurers pricing is the point at which you most likely will reach a satisfactory financial settlement. Understanding the risk factors is an important element of your strategy.

Now you understand the local environment and you know your cost, so you're home free, right? Wrong. Understanding the contract language, your responsibilities and all of the elements that make up the entire relationship are of equal importance. As described above, knowing the products that are covered under the agreement, understanding your rights under the term and termination clauses and paying particular attention to the division of responsibilities may make the difference between a highly beneficial relationship and an acrimonious and costly one.

Does Contracting in Managed Care Really Change the Way in Which Care Is Delivered?

A close look at managed care contracting reveals that, while there is a change in the reimbursement methodology and there is a greater reliance on communication with other providers and the insurer, many of the elements of delivering care are the same. The provider is still the final decision-maker for the vast majority of the care delivered. The site of care may change (i.e. from institution to home as an example), but all managed care companies are very aware of the sensitivities of the market and are not looking to disturb the patient/provider relationship.

Who to Contract with

Given the changing climate in the healthcare industry and the increasing pressures created by managed care, providers are increasingly being approached to contract with a number of different healthcare payers, each presenting itself as an effective managed care organization. In many cases, managed care is soliciting ever-increasing amounts of discounts for the services provided to providers, and are also trying to transfer the financial risk through various new compensation arrangements.

Managed Care Organizations are becoming increasingly sophisticated in their techniques and approaches to contracting with providers. As a consequence, providers need to understand the risks and rewards that

are inherent in these new risk arrangements, and the alternatives and strategies that are available to providers to optimize their position in this evolving health care environment. Providers need to do their homework before beginning negotiations with Managed Care Organizations. This research will allow the provider to compare and evaluate the different organizations, using specific parameters that have been developed based on the provider's specific situation. Data to evaluate includes:

- \$ Health Maintenance Organization's market position--assess the current position and request information about its forecasted growth.
- \$ Managed Care Organizations major employer groups--review current list.
- \$ Population being served--understand the age and sex mix, and any special risk groups within the population.
- \$ Gross revenues of the payer - compare on a per member per month basis.
- \$ Plan's performance. Assess changes and compare from last year to this year, (including but not limited to):
 - \$ Premium levels.,
 - \$ New enrollments over the 12 month period.
 - \$ Changes in the provider network, including the number of clinicians currently in the network (e.g. primary care vs. specialists).
 - \$ Likely referrers to rehabilitation vs. unlikely.,
 - \$ Changes in the medical loss ratio.
 - \$ Determination of current NCQA status.
 - \$ Key statistical information, days per 1000 members of hospital in-patient stay, hospital, Outpatient procedures or services, ER visits, Primary Care Physician office encounters.
 - \$ Profit and/or loss.
- \$ Health Maintenance Organization's growth plan.
 - \$ Determine potential for the next twelve months.
 - \$ Forecast of membership growth
 - \$ Plans for new products or services.
 - \$ Anticipated changes in premium requirements
 - \$ Proposed new benefit plans.
 - \$ Network changes.
- \$ Standard procedures and the providers' rights in areas of disputes -- determine who ultimately has the responsibility to accept or to choose a course of treatment for a given patient.

Much of the information discussed above can be obtained directly from the Health Maintenance Organization by making appropriate requests from the provider relations or network development staff person who is dealing with your organization. However, other sources are also available, including the annual financial reports for Health Maintenance Organizations that are collected by the Department of Insurance in many states. Most states will send this information to you upon request. In addition, many employers are requiring managed care organizations to seek accreditation from NCQA. Providers should use the NCQA information available through the Internet to evaluate Health Maintenance Organizations, both those with which you are currently affiliated, as well as those under consideration. This information can indicate the strengths and weaknesses of the current operation, and is fast becoming the mandatory stamp of approval for Health Maintenance Organizations.

So You're Interested in a Contract, Now What?

Once the decision has been made to contract with a Managed Care Organization, your next decision should be whether your organization should accept risk or capitation reimbursement. The primary concern here is that those who pay premiums into managed care organizations (usually employers) are increasingly forcing Managed Care Organizations into this kind of reimbursement by demanding lower premiums. Health Maintenance Organizations and other types of managed care organizations are in the business of trying to manage risk through a variety of arrangements. Most Managed Care Organization executives believe risk management is best accomplished by having all subcontractors share in the overall financial risk that is inherent when providing prepaid medical care to an enrolled population.

Managing Capitation

The most common approach to risk sharing is capitation. Capitation is a mechanism that transfers agreed-upon financial responsibilities from the Managed Care Organization to a provider group, thus making financial outcomes more predictable. However, when risk is transferred from one party, another party assumes the risk. Simply stated, someone's advantage becomes someone else's disadvantage. The following is a brief outline of some of the advantages and disadvantages of capitation arrangements to specific parties.

Capitator's (Payer's) Advantages:

- § Risk is shared with second party, thus minimizing unexpected valuations and costs.
- § Opportunity is provided to involve providers in risk assumption process.
- § Opportunity is provided for an incentive-based approach to managing providers (i.e. providers start to manage themselves).

Capitator's Disadvantages:

- § Some control over providers is lost since data collection is harder.
- § Providers unable to control consumption may become dissatisfied.
- § Negotiations and confrontations with dissatisfied providers may be difficult, with the potential of even losing contracts.
- § Quality appropriateness and effectiveness of care must continue to be monitored by the capiator.
- § Capitors must stand behind risk in most states, thus never fully transferring 100% of the risk.

Capitated (Provider's) Advantages:

- § Opportunities are created to preserve income through better management of services delivered.
- § Revenue flow is stabilized.
- § Links between patients and provider are stabilized.
- § Opportunities are created for exclusive contracting and/or improved potential to preserve patient base.
- § Providers are assisted in linking the cost of care to their practice patterns, thus better understanding how to manage care efficiently.

Capitated Disadvantages:

- § Additional technical skills are required, which are not typically available in a provider group.
- § Serious financial difficulties can arise when services are not appropriately controlled.
- § There is the potential for the capiator to take advantage of the provider by including more and

more services without appropriate increase in capitation.

- \$ Without careful analysis, a contract often sounds better than it really is.
- \$ A capital base for risk reserve is required to protect providers from statistical fluctuations.
- \$ A different means of funds distribution among the providers of their capitated populations is needed.
- \$ The providers are placed at financial risk, thus requiring them to set aside funds for potential losses (reserves).
- \$ The potential is created for additional administrative cost and the need for additional personnel or support services.

In addition to these advantages and disadvantages that each potential provider must evaluate in making its decision regarding risk, there are also operational issues that must be considered to determine the level of risk that is acceptable to each individual:

- \$ The number of members being enrolled through the capitation arrangement should be sufficiently large that the costs can be statistically predictable. This is called "the law of large numbers".
- \$ The reinsurance and stop loss provisions regarding the amount to be expended on any one case should be suitable to protect the rehabilitation provider from that risk.
- \$ The scope of services required under the contract should be well defined and within the capabilities of the provider.
- \$ The rate of claims used to calculate the capitation rate should be historically predictable and stable.
- \$ The provider should have the necessary resources to actually have an impact on the flow of patients and the services that they receive.

The Flavors of Capitation

There are six different types of capitation arrangements:

- \$ Primary care capitation
- \$ Global medical group capitation
- \$ Integrated delivery system capitation
- \$ Hospital capitation
- \$ Specialty capitation
- \$ Individual service capitation

Primary care capitation requires a primary care assignment where members choose a Primary Care Physician or where one is assigned to them. Capitation implies that a specific set of services is paid on a fixed monthly fee per member. Sometimes the capitation risk is adjusted to recognize varying components in consumption patterns or cost levels, i.e. age/sex adjustments. Many times primary care capitation is also accompanied by various incentive risk pools, where rehabilitation providers can share in savings that accrue for reduced utilization of specialty services and hospital care. Rehabilitation providers are party to these agreement only as part of integrated health systems.

Global medical group capitation is an extension of primary care capitation, but usually covers all rehabilitation provider services. Thus, a patient chooses a medical group and the services covered include physicians specialty care as well. This approach works well for medical groups, medical specialty clinics or

rehabilitation provider care clinics. This form of reimbursement can also be used for Independent Practice Associations (IPAs), and in some "group practices without walls". A key component of how successful these programs are within each respective provider group is predicated on the various means of distribution of the cap revenue to the individual members of the medical organization. In most cases, Independent Practice Associations will tend to reimburse their existing rehabilitation providers on a fee-for-service basis, and do not have appropriate incentives set up to effect the kinds of medical care changes that are necessary for capitation to be truly successful within these types of organizations. If rehabilitation services are part of those offered by the medical group, rehabilitation may be included in this type of capitation arrangement.

Integrated delivery system (IDS) capitation is a further extension of the capitation approach. This is the ultimate in risk transfer for a health plan, and almost all services, including rehabilitation, are capitated, thus passing all the financial risk from the health plan to the provider. This approach can be very successful for those provider groups that have the internal structure and the financial strength to assume this level of risk. Rehabilitation services are usually included as integral components of the IDS.

Hospital capitation is relatively new and is increasingly popular. Historically, hospitals have been compensated on either per diem or DRG rates, and in some cases, discounted fee-for-service for specific inpatient services. However, with the changing environment, hospitals have looked more favorably upon accepting capitation in many markets. Typically, the facilities tend to try to lock in their current revenue levels and try to achieve financial improvement by attacking utilization patterns within the institution. Rehabilitation services are included for acute care inpatient services as offered by the hospital.

Specialty capitation, including rehabilitation services, is also increasing in popularity. These arrangements are sometimes called "carve out" capitations. Common examples include rehabilitation services, mental health, radiology, pathology, oncology, and cardiovascular services. However, one should be sure when considering these types of arrangements that the number of patients covered is large enough to spread the risk over a reasonably sized population.

Specialist Contracting

In today's managed healthcare milieu, managed care organizations (MCOs) are looking for rehabilitation provider partners to provide their subscribers an agreed-upon set of rehabilitation services for a fixed amount of money per month. The Managed Care Organizations have accepted a fixed premium for the provision of all medical care, either from the government, other third parties, or commercial companies. Now they need someone to deliver the care. Rehabilitation providers have an important role to play in managing this risk assumed by the Managed Care Organization, by providing rehabilitation management to members in a cost conscious manner. This sharing of risk is often in the form of capitation. Over the past several years this approach to managing the cost of care had been handled by primary care providers, requiring them to act as gatekeepers. However, specialists are now being given the opportunity to also accept capitation. Nevertheless, many specialists, including rehabilitation providers, still consider a discounted fee for service approach more appealing. If a specialist is to contract with a Managed Care Organization, he or she must accept a number of somewhat unpalatable changes in the way the practice will be managed. These include most significantly, reductions in reimbursement levels, access to patients controlled through primary care gatekeepers, and increased administrative requirements necessary to perform effectively in a managed care environment.

Patient access to specialists has changed. With a Health Maintenance Organization gatekeeper model, a patient can not make an appointment directly with the specialist. The specialty network is usually designed by the managed care organizations (MCOs), and can make referral relationships more difficult to maintain. Physician gatekeepers have increased professional risk. The ordering of diagnostic tests and additional referrals "just to be sure", is scrutinized by the Managed Care Organizations through their referral and utilization management processes. In many ways, the physician and rehabilitation provider maybe held to higher standards in servicing a patient, standards with which many of them do not agree, and are not accustomed to meeting. Additionally, clinical pathways by condition, stipulating what some refer to as "recipes" for services, are now being widely recognized and utilized, requiring the clinician to deliver medical service in accordance to the Managed Care Organization's clinical pathways, and not necessarily to his or her professional judgement alone.

Despite all these changes, rehabilitation providers must consider capitation as an option as they look to the future. Increased participation in managed care is often critical to the success of their practice. Accepting a capitation to guarantee volume and ensure income will be a necessary part of a specialist's business plan in the 2000's.

Why Rehabilitation Providers Should Capitate

There are a number of advantages and concerns a rehabilitation provider should consider when reviewing a capitation opportunity. The following reviews the advantages and disadvantages of capitation agreements.

Advantages of capitation

- \$ Guaranteed volume. Willingness to accept the capitation means a guaranteed volume of business. It also means that the capitated rehabilitation provider gets the business, not the competition.
- \$ Guaranteed income. The practice is guaranteed a check at the same time every month. Though it may not be as much as in a fee-for-service arrangement, it does bring a given cash flow to the books each month, free from the depredations of bad debt, untimely payment, write-offs, referral authorization problems and copayments.
- \$ Technical service income. Most capitation arrangements are for professional services only, and not for any technical service, such as facility fees or tests that may be provided. If your practice performs these additional services, additional compensation can be expected.
- \$ Practice development and expansion. Some practices have been able to expand their practices, locations, staff and services because of payment guarantees.
- \$ Better payer relations. By accepting a capitation with a payer, and sharing risk, long-term partnerships can develop, ensuring a more solid practice.
- \$ Market Share. With guaranteed volume, a rehabilitation provider's market share in the community grows. Remember that capitated patients will have other insured friends.
- \$ Reduced administrative costs. At an average cost of \$3.50 for every indemnity claim a rehabilitation provider's billing department processes, the fact that there are no claims to process with capitation saves considerable time and money. Utilization review forms are generally the only forms requested.

Capitation - Not for the Timid

Capitation, however, is not a panacea. There should be a fear that when you accept capitation, you are at risk for overutilization by your referral sources. Remember, unless you are sub-capitated from the Primary Care Physician, it doesn't cost the Primary Care Physician any more to send two or ten referrals to your practice. You will need to perform time-consuming utilization monitoring and education of the primary care physicians toward more appropriate referral patterns. By working with your referring physicians to improve communication, successful relationships can be achieved.

You must clearly understand the full costs of your operation in order to monitor the capitation rate accepted. You must first determine what ultimate discount from fees is acceptable. You can monitor the success of the cap rate by comparing the claims produced but not sent for collection, to the capitation check each month. Of course utilization will vary month to month, so it is important to compare the capitation payment to fee-for-service utilization over longer periods, such as quarterly, semi-annually, and annually. An investment in a system that can perform this function and provide tracking requirements for each Managed Care Organization will be essential.

Initially the provision of quality services under a capitation may seem excessively costly; and unfortunately there may appear to be incentive to cut costs by reducing services. Don't take this approach-it will invariably be most costly in the long run. You may need to gain greater understanding of critical pathways in order to assume effective and efficient protocols for provision of care. This will be critical to your long term success in capitation.

Obtaining a Capitation Contract

In competitive managed care arenas, the choice of accepting a capitation is often not as difficult as obtaining the opportunity. Today, with so many full risk capitation contracts being accepted by Physician Hospital Organizations and Independent Practice Associations, a rehabilitation provider may need to be more creative in accessing the market: A rehabilitation provider could accept a cap directly with a payer, or through an Independent Practice Association or Physician Hospital Organization, (referred to as a horizontal cap). He or she might also accept a capitation directly from an independent medical group, (sub cap), or from a rehabilitation provider management group.

Rehabilitation providers in many markets share these arrangements with their competitors in order to obtain large volume opportunities. Volume direction, whereby utilization is tracked by an agreed fee-for-service measurement, and the monthly capitation checks divided according to the FFS utilization, is an example of a common methodology. However, this model has been known to create incentives for overutilization. A more successful mechanism has been to review the procedures performed at the end of each month, weight the procedures in the same manner as RBRVS, for example, and divide the income (See appendix for using RBRVS to develop a rehabilitation fee schedule). Typically, the Independent Practice Association, Physician Hospital Organization, or medical group assumes the responsibility for the implementation of this shared process.

How a Specialty Capitation is Developed

Consider a staff model Health Maintenance Organization's approach to managed specialty care: Here is a group practice, usually multispecialty, where the rehabilitation providers are employees of the Health Maintenance Organization. A staff model is considered the dinosaur of the models today, but a review of some of their methods can be a guide to establishing a capitation arrangement for your rehabilitation practice. The Health Maintenance Organization may not always have the patient volume in certain

geographic areas necessary to support the employment of all types of full time rehabilitation providers, so they look to prepay the part-time services they cannot support full time.

There are a series of steps to take in creating a viable capitation rate.

- § First, the rehabilitation provider's costs are reviewed for a particular population, based upon the previous years' fee-for-service experience.
- § Secondly, the cost of *employment* of a clinician providing that service for the same population (a competitive salary package, including the cost of benefits and malpractice insurance) is determined.
- § Thirdly, the fee for service revenue for that population and that year is compared to the cost of employment of a rehabilitation clinician to perform the same services, and the cost of supplies and overhead. This comparison will determine the level of revenue needed by the rehabilitation provider to perform the service and enjoy a reasonable profit. The profit is the negotiable area.
- § Fourthly, the annual cost plus profit is divided by the population size, and then divided by 12 to determine the monthly capitation rate.
- § Finally, the rehabilitation provider should do reasonable due diligence, and compare his or her results with a number of national capitation surveys, to substantiate the cap rate determined.

Your practice must decide what level of discount represented by the capitation is ultimately acceptable. Like all other health care costs, capitation rates are market driven. Discounts represented by capitation range nationally from 50% to 75% of charges. One Health Maintenance Organization in Chicago found its benchmark accepted by aggressive, market conscious physician groups to represent about 45-55% of charges, or 80-90% of Medicare reimbursement.

The best choice for a rehabilitation practice today would be to achieve a balance of all payment mechanisms. The advantages of accepting a capitation arrangement as part of the rehabilitation provider's strategy will outweigh the risks. Capitation arrangements combined with utilization management, and favorable relationships with your referrers especially Primary Care Physicians (following the managed care lead of the strongest referring physicians), are key elements to a rehabilitation provider's business plan today.

Implications of Managed Care Success for Rehabilitation Providers

One of the keys to success will be developing a continuum of care within your rehabilitation practice. This is not easily or inexpensively done, but success here insures financial success as well.

Once you understand the differences within the levels of care and programs, it is important to identify points of interface that make sense within the full continuum. Through committee and/or work group structure, you may want to create a mechanism to encourage communication among managers and rehabilitation providers. There are several key elements that should be worked on at both a management level and a committee level. These are:

1. **Cultural differences between the disciplines and between points of care along the continuum.** Therapists and nurses can be successfully shifted between similar cultural environments, but random shifts and reassignments can undermine a continuum of service. Similarly, the administrative and management shifts that occur when a single person is given responsibility for a full continuum of services can have a different impact on staff, depending on the culture of the group or program from which the new administrator came. These issues need to be clearly explored before they occur so that appropriate staff expectations will develop.
- **Patient service needs.** When moving patients through the continuum of care, the primary consideration must be patient safety and service. Traditional models of health care, many

- patients received a higher level of care and had longer lengths of stay than what was medically necessary. Today, we must consider patient needs and resources to maximize their care and function while minimizing resource utilization. This may require discussion with patients regarding reasonable expectations for themselves and their care givers.
3. **Reimbursement issues.** Because of the different reimbursement mechanisms of various payers that may be in effect for each level of care, patients may sometimes be appropriate for admission to more than one service level. It is important that patient transfer issues consider not only appropriateness of medical care, but maximization of available reimbursement. This requires a commitment to review these issues consistently and to monitor changes in reimbursement. Internal turf issues are also common barriers to success in this area.

Cultural respect and system commitment to the continuum. Education is needed among the levels of care to develop respect and understanding of each component's distinct abilities and opportunities and limitations. While the development of a single culture may be difficult, achieving an understanding of one another and a reliance upon the skills of all team members will be key to the success of the continuum. This can occur only if the system is committed to developing a true continuum and is willing to take the time required for behavioral change. Leadership example and behavior modeling will be critical to establishing this respect.

Clinical pathway development. Clinical pathways are an excellent tool to link levels of care and to eliminate or reduce "competition" for patients between and among different levels of care. When pathways are created within a continual environment rather than a level-of-care environment, it is easier to ensure appropriate resource consumption.

6. **Case management.** Internal case management systems and support must exist throughout the continuum of care, using clinical pathways and other management tools to manage patient flow. Case managers often become the intermediary between the providers and the payors, as well as the moderator among levels of care. The goal is to maximize patient outcome while managing service utilization to support the patient and health care provider.

Ultimately, the shift from a single level of care to continuum of care is more than just the placement of services under a single manager or operational system. It is the interface of location, culture and reimbursement to best manage patient care and use of resources. Gaining a solid understanding and a sincere respect for the different cultures and reimbursement structures is important to the success of this continuum.

Summary

This chapter has examined the management strategies most frequently found in managed care arrangements. Combined with the clinical strategies reviewed in Chapter 5, these strategies will describe the full spectrum of currently utilized structures and systems in managing managed care from the rehabilitation provider's perspective.

Chapter 7

The Balanced Budget Act of 1997

Au Note: Removed – No longer relevant

Future Trends in PM&R and Managed Care

Au Note: Enjoy these 1998 predictions

Overview

Preview of Major Topics

Uncertainty of the Future

Risk Sharing

- Why risk sharing is attractive
- The problems with risk sharing
- Most likely risk sharing structures in the future
- Implications of risk sharing for rehabilitation providers

Capitation

- Most likely capitation structures in the future
- Why capitation is attractive
- The problems with capitation
- Implications of capitation for rehabilitation providers

Provider Networks

- Forms of provider networks
 - Horizontal networks
 - Vertical networks
- Most likely network structures in the future
- Why networks are attractive
- The problems with networks
- Implications of networks for rehabilitation providers

Managing in the future

- The Adaptive Clinician
- Developing and managing the adaptive clinician
- The virtual organization
- Managing change
- Defining and measuring success
 - Clinical
 - Managerial
 - Organizational
- Professional and personal rewards in the future

Uncertainty of the Future

The title of this chapter is more than just a bit daunting to the authors. Whenever there is the opportunity to predict what will happen, there is the chance to just get it wrong. In the preparation of the initial seven chapters of this book, there was significant consideration given to being sure to be able to back up all the statements with references and credentials. Although we have certainly not deterred from that course in this chapter, there is significantly more room for discussion and individual interpretation. Our intent is to identify those areas of rehabilitation and managed care that are likely to have the most significant impact on our professions and the care that we provide to patients.

Clearly, the future is uncertain. The view is a bit foggy. As we move closer to the full implementation of The Balanced Budget Act of 1997, the fog will probably clear a bit. A critical question to address as we

end this book is, What if the fog clears and we are able to get a crystal clear view of a future that we do not like? We have heard this question and other similar questions for many years now. Those who came before us probably heard it, too. Anxiety about what will happen is normal. That anxiety can become problematic when it precludes us from taking action.

The Future of Rehabilitation Remains Bright

There are several alternative scenarios that one could project for the future. Some are very positive. Some are more negative in their perspective. Legislation, regulation, market pressures, and the industry itself will take many curious turns over the next few years - some for the best, others not. One constant that must be calculated into any projection or scenario of the future is the rehabilitation professionals themselves.

As we examine the future of our profession, it is necessary to factor in the professional and personal traits of the therapists, physicians, nurses, assistants, technicians and others in the mix. Those traits include some wonderful ingredients for the preparation of a successful future: intelligence, compassion, conscientiousness, integrity, industriousness, creativity, beneficence, loyalty and flexibility. There are many more, too many to list. The first eight of these traits are what makes us what we are - successful, important members of today=s health care team. The ninth trait, flexibility, makes us what we will be - successful, important members of tomorrow=s health care team. The only thing we know for sure about the future is that it will be different than today - probably dramatically different. What will allow us to find our place will be the flexibility to journey and discover that role. Along that journey we will need every one of the other traits to succeed in that new role, but it will be flexibility that will allow us to believe and then see what we need to do. . Today seeing is believing. The future of rehabilitation will be a believe and then see world.

How will The Balanced Budget Act of 1997 play out?

This first question to be answered as we move to the future of rehabilitation has to do with The Balanced Budget Act of 1997. At press time for this book, there seemed to be as many questions about the specifics of implementation as there were known facts. Several key questions to continue to ask - and hopefully answer soon - regarding The Balanced Budget Act of 1997 are:

Rehabilitation Continuum

- What impact will The Balanced Budget Act of 1997 have on the balance of the continuum?
- Which venues will be the winners and losers under The Balanced Budget Act of 1997?
- Will it be necessary to participate in an integrated delivery system to survive?
- How can private practitioners insure their survival with respect to future reimbursement strategies?

Outpatient Rehabilitation Services

- Does the future hold a place for rehabilitation agencies, CORFs and independent practice outside of integrated delivery systems?
- What will happen to profoundly impaired, multiply handicapped patients with the demise of cost reimbursement in all settings?
- What will we do to learn how to provide quality care in a \$1500.00 capped world?
- What changes, if any, will there be to how the cap is applied? Will PT and Speech be separated under the cap?

- Will the fee schedule be uniform for all outpatient settings? All disciplines?
- Will there be fewer safety nets for society? Will those safety nets that are left be enough to prevent increasing numbers of society from falling through the cracks?

Skilled Nursing Facilities

- What will we do to learn how to provide quality care in a post salary equivalence world?
- What impact will consolidated billing have on the spending and referral patterns of SNFs?
- Will subacute rehabilitation continue to thrive and expand?

Home Health

- How long will it take home health care agencies to understand the nuances of prospective payment?
- What role will rehabilitation play in this typically nursing dominated industry now that the agencies essentially become internal purchasers of rehabilitation services?
- How will rehabilitation clinicians and managers remain or become influential with the home health agency now that rehabilitation will be viewed as an expense rather than a revenue?

Hospitals

- What will the diagnostic groups be that will be subject to redefinition of discharge to post acute care?
- How quickly will the remainder of the DRG be subject to redefinition of transfer for early discharge?
- What will hospitals do with patients who are ready for discharge in significantly less time than anticipated under PPS?
- When, if ever, will hospital based rehabilitation be subject to a cap? To prospective payment systems?

Rehabilitation Units and Hospitals

- How long will it take PPS exempt rehabilitation programs to understand the nuances of prospective payment?
- Can rehabilitation units and hospitals exist outside of an integrated delivery system?
- What impact will the redefinition of discharge in acute care have on inpatient rehabilitation programs?

Where Medicare Goes - So Goes the Market

Quality in Medicaid and Medicare

As the number of beneficiaries enrolled in managed care plans has increased, the Clinton Administration has been working closely with states, insurers, health care professionals, and consumers to assure the quality of care provided in that setting. Several initiatives are already underway. For example: Medicaid Health Plan Employer Data Information Set (HEDIS) was developed in partnership with the National Committee for Quality Assurance (NCQA) to provide states, managed care plans, health care professionals, and consumers with the information and tools they need to assure high quality in managed care plans serving Medicaid beneficiaries. Medicaid HEDIS is an adaptation of the commercial sector's

HMO performance measurement system used by more than 300 private plans. Medicaid HEDIS will provide states with information on the performance of their Medicaid managed care contractors, assist managed care plans in quality improvement efforts, support efforts to inform Medicaid beneficiaries about managed care plan performance, and promote standardization of managed care plan reporting across the public and private sectors. Medicaid HEDIS was released to the states in February 1996.

Medicare HEDIS is a parallel effort in partnership with the Kaiser Family Foundation to establish a proven performance measurement system that will minimize reporting burdens on managed care plans serving Medicare beneficiaries. The new measures will help plans to improve the quality of their care and support efforts to improve the health status of beneficiaries. HCFA began requiring plans to submit Medicare HEDIS data as of January, 1997.

There are several key themes that we will address as we look to the future. They are presented in no specific order. These themes are:

- Risk sharing arrangements will become more prevalent
- Capitation will become more prevalent but only as one choice for risk sharing
- Integrated delivery systems will dominate the managed care market. Rehabilitation networks will continue to develop.
- Consolidation of providers and payers will continue
- For profit health care will survive and compete in most, if not all, major markets
- The nature of management will evolve. Managers will require a different skill set than that which is commonly found today.
- The nature of clinical care will evolve. There will be greater emphasis on non-hands on clinical skills such as case management, productivity, and outcomes analysis. Professionals in rehabilitation will develop new definitions of success and personal rewards from the work of rehabilitation.
- Niche specialization will survive and thrive but not within the typical managed care environment.
- Disciplinary boundaries will blur, cross training will proliferate and there will be increased pressures on the educational systems to produce a multi-skilled professional.
- Consumerism will become a strong force within all of health care as the American public struggles with health care cost and quality issues.

Trend #1. Risk Sharing Arrangements Will Become More Prevalent

Why risk sharing is attractive

In risk sharing arrangements, the provider assumes some or all of the financial risk for providing health care to the patient. In contrast to the traditional model where the insurer or payer assumes all the risk, there is an incentive to the provider to control costs. A strong argument can be made that the party with, potentially, the greatest impact on cost is the provider. Without risk sharing, the provider may actually have incentives to escalate health care costs. Additionally, risk sharing is attractive to high quality providers because it is likely to drive poor quality providers out of the market. Accountability, in any form, is likely to discourage ineffective care.

The problems with risk sharing

Risk sharing is not a panacea. By definition, risk sharing arrangements have an element of risk (no humor intended). Unless the arrangement is properly structured, the provider may find themselves in a

situation that not only encourages less care, it may actually punish appropriate quantity and quality of care.

There are potential conflicts of interest for providers inherent in these arrangements unless properly structured. Many rehabilitation professionals have, historically, been concerned about financial arrangements that encouraged referral for profit situations, such as those addressed by legislative actions of Stark I and II. Risk sharing arrangements can produce financial arrangements that encourage referral for profit conflicts of interest - from referral sources and from within our own practices. The potential harm to patients and abuse of the system are likely to be just as great as in referral for profit.

Implications of risk sharing for rehabilitation providers.

If rehabilitation providers are to enter into risk sharing arrangements, it should be with full awareness of the advantages and disadvantages of these arrangements. This will require a significant level of study and reflection on the part of many rehabilitation managers. There will also be increased need to consult with experts from non-clinical areas such as accounting, finance, and epidemiology. A high level of familiarity with statistical analysis will also be needed.

As managers of rehabilitation programs, it will also be necessary to develop sustainable systems to educate staff and then help staff develop the appropriate skills concerning managing patient care in a risk sharing environment.

An additional area of attention for many rehabilitation providers will be the need to develop an adequate information infrastructure and data processing system to be able to accurately measure performance and anticipate areas of concern in a timely fashion.

Trend #2. Capitation will become more prevalent in rehabilitation but only as one choice for risk sharing.

Capitation can occur in a variety of forms and structures. Each with its own advantages and disadvantages. Chapter Six reviews these in detail. The most likely capitation structures in the future will be based on PMPM (per member per month) calculations or a percent of benefit dollar approach. Each of these is currently in use to some extent in most areas of the country.

PMPM calculations are the most common. The advantage of PMPM models is that there is often a well defined logic to the negotiations since they are based on utilization and epidemiologic data. Hopefully, the data used for calculations is accurate and meaningful. Sometimes it is not. At best, PMPM calculations remain a best guess and require extensive contract language to define exclusionary conditions such as extreme miscalculation of utilization or demographic composition of the pool. PMPM calculations are somewhat retrospective in nature in that they are based on data of varying ages. Current data is rarely available. The projections are based on past data - and past practice patterns.

Recently, there has been an increase in the practice of determining capitation rates based on the provider accepting a negotiated percent of benefit dollar paid by the member. The range is often 80-88% of the total benefit dollar to accept the risk of providing health care to the member pool population. The managed care company retains the balance for administrative overhead related to marketing, contract administration, liability insurance, credentialing, accreditation and profit. A concern of many who have entered into these types of agreements is that the actual payment to the provider is based as much on the benefit rate as on the negotiated percentage rate. In a highly competitive managed care market, benefit rates may decrease. In this scenario, the payment to the provider would also decrease. The financial risk the provider assumes, however, does not decrease. An additional concern in percent of benefit dollar capitation is that the capitation payments are not based on utilization or cost data - rates are merely negotiated based on dollars available from member benefit receipts. The logic, however fragmented,

inherent in the PMPM method is absent in this payment methodology.

Capitation is attractive for many obvious reasons to the payer. Transferring risk to the provider in essence allows the payer to stop being an insurer. The business activities of the payer in a capitated environment are similar to a middleman or broker in the financial world. Economic projections are much easier for the payer in a capitated world and there is less opportunity for surprise. All of these are viewed as positive in the eyes of the payer.

For the provider, the threats inherent in capitation are obvious. Capitation can provide many opportunities to the payer. The learning curve in capitation is steep for the provider.

Implications of capitation for rehabilitation providers

In heavily penetrated and competitive managed care markets, capitation may be necessary whether the provider is ready to accept the risk or not. This is not territory for the faint of heart. Risk is often hard to quantify. Because of this, new structures for risk sharing between payer and provider will become more attractive. True partnerships where there is equal and mutual risk sharing is becoming available in a wide variety of business arrangements. We feel that as the managed care markets mature, these will continue to grow in importance along with capitation arrangements.

Trend #3. Integrated delivery systems will dominate the managed care market. Rehabilitation networks will continue to develop.

One of the most substantial advantages of developing an integrated delivery system with a full continuum of patient care is the ability to more significantly influence the care path that individual patients take. If an organization is to assume risk for costs throughout the continuum (something that is very desirable to the payers) it will be necessary to be able to control the costs incurred along that continuum. The traditional fragmented health care system examined the path that the patient takes through the system as a series of discreet, disconnected stops. At each stopping point on the continuum, there were certain financial incentives that often were in conflict with the incentives elsewhere along the continuum. This created a situation where the providers at each stop in the continuum, acted in complete isolation from the rest of the continuum. Sometimes in ways that were not to the patient's best long term interest.

In a fully integrated delivery system, there is an alignment of the financial incentives throughout the continuum. The patient care managers in managed care can then plan the best, most cost effective path through the continuum without regard to individual stops along the way.

Unfortunately, this presents some competitive problems for providers who are not part of an integrated health system. To address this competitive disadvantage, it will become increasingly necessary for independent rehabilitation providers to form collectives. Every indication is that this will be required for financial survival-especially for providers interested in serving managed care members. One exception to this requirement will be the niche provider (see Trend # 8).

Provider networks can take many forms and can have a variety of connection points as the basis for the network. Horizontal networks include collectives of similar providers, such as physical therapists in independent practice or speech language pathologists in voice labs. These providers can also be individual integrated delivery systems. Rarely, if ever, do members of horizontal networks compete in the same geographical area unless there is little overlap of services. Examples of horizontal networks are Physical Therapy Provider Network and Voluntary Hospitals of America.

Vertical networks usually exist in a single geographic region and connect dissimilar providers along the continuum of health care. The end result is often, but not always, a virtual integrated delivery system (IDS). There must be little internal overlap of services in a vertical network so that internal competition

does not interfere with the virtual IDS. Independent rehabilitation providers may choose to join with other independent health care providers or with existing integrated delivery systems in these networks. It is likely that both of these network structures will be prevalent in the future, however, the long term viability of small rehabilitation providers in vertical networks has been questioned.

Trend #4. Consolidation of providers and payers will continue.

Partially due to the expansion of integrated delivery systems and the natural maturation of health care as an industry, there will continue to be massive consolidation of providers for the foreseeable future. In spite of poorly demonstrated financial benefits from the merger mania of the late 1980's through the 1990, this trend will continue until many major markets will contain only 2-5 major health care providers.

The same trend will continue to occur with payers.

An additional trend will be the continued convergence of payer and provider into a more traditional managed care model. As healthcare moves toward the management of the health of large populations, this trend will be inevitable.

Trend #5. For profit health care will survive and compete in most, if not all, major markets.

There is considerable strength in both not-for-profit and for-profit health care at this time. Although the popular media has enjoyed some of the fallout of what at first examinations seems to be greed and wretched excess in several large for profit providers, there are significant advantages to proprietary health care. Not the least of which is deep pockets. Investor owned health care companies will continue to be viable as long as health care continues to be profitable. This is not to suggest that the manner in which health care is delivered will be identical in these two systems, it will not. Clearly, there will be significant overlap of many services and practices, but there will also be areas of divergence. Rehabilitation services will continue to be an area of overlap, but specific segments of rehabilitation may fall into areas of divergence. For the authors, this will be one of the most interesting acts in the upcoming health care play.

Trend #6. The nature of management will evolve. Managers will require a different skill set than that which is commonly found today.

There will be a greater emphasis on having fewer, more highly trained managers in the future. Overall, this likely to be a positive step for rehabilitation programs. The locus of control and authority for rehabilitation decision making will be more concentrated and there is some risk that fewer managers may be less able to mentor and guide staff. This may well be the case.

The future rehabilitation manager will need to have skills to function in a virtual organization, such as those created by vertical or horizontal networks or providers. This is likely to challenge many of the existing management systems related to communication, performance planning and appraisal, supervision and professional development. Generic management skills rather than highly refined, discipline specific clinical leadership skills will be needed in the top management of rehabilitation programs. This is not to imply that discipline specific clinical skills will not be needed, they will. These clinical skills will be even more important in the future - but they will need to be disseminated among a variety of clinical staff throughout the continuum of rehabilitation care. Master clinicians, senior therapists and in-house mentors will become invaluable members of the leadership team. Although this is true today, it will become even more important as we progress to a more mature managed care future.

Multi disciplinary supervision will become commonplace. There is likely to be a period of interdisciplinary strife as clinicians and individual discipline leadership progress on the learning curve to multi disciplinary supervision. The individual professional associations have already begun to address these issues and will

need to continue to do so.

Managing change will become a major component of the rehabilitation manager's activities. The overall adaptability of the practice will be an important indicator of likelihood of success.

Developing and managing the adaptive clinician will also be challenging for the rehabilitation manager.

This will be addressed more in Trend #7.

Trend # 7. The nature of clinical care will evolve. There will be greater emphasis on non-hands on clinical skills such as case management, productivity, and outcomes analysis. Professionals in rehabilitation will develop new definitions of success and personal rewards from the work of rehabilitation.

The hands on clinical skills needed to care for patients must continue to be developed and delivered as the focal point of each rehabilitation profession. This represents the uniqueness of each profession. The uniqueness is what adds value to the rehabilitation care that is delivered to each patient. However, individual practitioners will need to evolve into what we will call the adaptive clinician. The adaptive clinician is one who is fully aware of the environment in which they practice. This includes issues internal to the rehabilitation department and the integrated health system in which they practice and issues in the more global rehabilitation industry. It also includes general societal and political issues affecting the profession and the customers and patients they serve. Hands on clinical skills will continue to be necessary to define the unique characteristics of clinical practice in all areas of rehabilitation but a greater emphasis will be placed on non hands on clinical skills such as critical thinking, problem solving, time management, self assessment, organization influence, professional behavior, interaction with external customers, supervision of assistive staff and continued self-motivated learning.

Defining and measuring success personal and professional success will need to be re-examined for many experienced clinicians. Things that many practitioners value to a very high degree such as intense one on one time with individual patients and professional independence will feel pressure from an emphasis on productivity and standardization. Neither of these latter two are necessarily negative, but they may be perceived as so by some clinicians. The rehabilitation manager will need to help staff members address these concerns and discover strategies to make the inevitable transitions more comfortable and tolerable.

Some clinicians are likely to choose to not make that transition. There will be some attrition as the rehabilitation industry changes. There always is with change. The extent of this attrition is unclear at this time to the authors.

Professional and personal rewards in the future will also change. The various currencies of reward that currently are viewed as valuable to many staff may need to be re-examined.

Trend # 8. Niche specialization will survive and thrive but not within the typical managed care environment.

The picture that has been drawn by the first seven trends that we have identified would seem to suggest that there is no place for the highly specialized or niche clinician in the changing rehabilitation landscape. This is simply not true. Master clinicians and narrowly focused practices will continue to thrive as we move into a highly managed care future. These practices will seek and eventually find specialty markets that will likely be able to support them. These markets, however, will either be outside of the managed care population or as carve-outs within the managed care world. It is likely that a very highly demonstrable degree of excellence will be needed to succeed as carve-out specialists. Managed care organizations view specialists who are not within the typical provider panel as out sourcing. Outsourcing brings with it a perceived loss of financial control to the MCO.

An additional market that will be attractive to rehabilitation master clinicians and niche providers will be the patients who are willing to pay out of pocket for services not considered a benefit under their managed care plan.

Trend # 9. Disciplinary boundaries will blur, cross training will proliferate and there will be increased pressures on the educational systems to produce a multi-skilled professional.

Rehabilitation professionals have enjoyed high demand and equally high salaries throughout the recent past. This is beginning to change as the supply of clinicians begins to approach (some would argue exceed) the demand. Issues related to professional autonomy and clinical uniqueness have begun to be actively examined in many practices in many geographic areas of the country. We believe that this will continue. There will be trials and pilot projects to examine the potential benefits and pitfalls of the multi skilled professional. This is likely to be especially true in larger integrated delivery systems. Although the authors do not view multi skilled professionals as a viable long term solution, it is likely that there will be efforts to encourage the development of educational programs and regulatory endorsement of these hybrid professionals. The response of the various professional associations to date has been strongly in opposition to this phenomenon. That is likely to continue.

Trend #10. Consumerism will become a strong force within all of health care as the American public struggles with health care cost and quality issues.

Managed care has often come under direct and very vocal attack from various consumer groups and the popular media. This is likely to continue. Many groups are beginning to develop sets of guidelines or standards for the managed care industry. The next section is a sample of some of these related to consumer protection. The health plans and consumer organizations have identified consumer protection principles, purportedly to promote quality health care and restore trust in the health care system. It is intended that these principles will be incorporated into legally enforceable national standards. What follows is a brief summary of those principles:

Consumer Protection Principles for Managed Care Organizations

1. Accessibility of Services.

To ensure access to quality care, health plans should have enough physicians, specialists, and other providers to provide timely, appropriate care 24 hours a day, seven days a week; provide women members with direct access to obstetricians and gynecologists; provide access to specialists and specialty care centers affiliated with the plan pursuant to treatment plans, including standing referrals to specialists; provide out-of-network referrals at no cost to the member when the health plan does not have a network physician with the appropriate training or experience or when the health plan does not have an affiliation with a recognized specialty care center to meet a member's covered medical needs; and provide health care materials and services in a culturally and linguistically sensitive manner.

2. Choice of Health Plans.

Individuals should be given a choice of health plans.

3. Confidentiality of Health Plan Information.

There should be strong protections against improper disclosure by health plans of medical information. Health plans should ensure that the confidentiality of member or patient information is protected.

4. Continuity of Care.

Members should be allowed to choose their own primary care physician and change their primary care physician at any time. Health plans should promote preventive care and ensure that medical records are complete and available to members and their providers.

5. Disclosure of Information to Consumers.

Health plans should provide consumers with information, such as: a description of the coverage provided and excluded, how to obtain service, select providers and obtain medically necessary referrals; members cost-sharing requirements; the names and credentials of the plan's physicians; a description of the methodologies used to compensate physicians; procedures for utilization management; a description of restrictive prescription drug formularies; procedures for receiving emergency care and out-of-network services; procedures for determining coverage for investigational or experimental treatments; use of arbitration; disenrollment data; and how to appeal decisions, file grievances, and contact consumer organizations, such as ombudsman programs, or government agencies regulating the health plan.

6. Coverage of Emergency Care.

Health plans should cover emergency services, including services provided when a prudent layperson reasonably believes he or she is suffering from a medical emergency.

7. Determinations of When Coverage is Excluded Because Care is Experimental.

Health plans should have an objective process for reviewing new drugs, devices, procedures, and

therapies. Plans should also have an external, independent review process to examine the cases of seriously ill patients who are denied coverage for experimental treatments.

8. Development of Drug Formularies.

Health plans that cover prescription drugs and use restrictive formularies should allow physicians to participate in the development of the formularies and provide for an exception process when non-formulary alternatives are medically necessary.

9. Disclosure of Loss Ratios.

In order to allow consumers to learn what percentage of their premiums are paid out in medical benefits, health plans should uniformly calculate and disclose how much of premium dollars are going for health care delivery costs rather than for plan administration, profits, or other uses.

10. Prohibitions Against Discrimination.

Health plans should not discriminate in the provision of health care services on the basis of age, gender, race, national origin, language, religion, socioeconomic status, sexual orientation, disability, genetic make-up, health status, or source of payment. Health plans should develop culturally competent provider networks.

11. Ombudsman Programs.

Consumers should have access to, and health plans should cooperate with, an independent, external non-profit ombudsman program that help consumers understand plan marketing materials and coverage provisions, educate members about their rights within health plans, investigate members' complaints, help members file grievances and appeals, and provide consumer education and information.

12. Out-of-Area Coverage.

Health plans should cover unforeseen emergency and urgent medical care for members traveling outside a plan's service area.

13. Performance Measurement and Data Reporting.

Health plans should meet national standards for measuring and reporting performance in areas such as quality of care, access to care, patient satisfaction, and financial stability. Standards should ensure appropriate confidentiality and protection of individual privacy. Health plans should disclose the results of performance assessments and be subject to independent audit to ensure accuracy.

14. Provider Communication with Patients.

Health plans should not limit the exchange of information between health care providers and patients regarding the patient's condition and treatment options. Health plans should not penalize providers who in good faith advocate for their patients, assist patients with claims appeals, or report quality concerns to government authorities or health plan managers.

15. Provider Credentialing.

Health plans and provider groups should develop written standards similar to those used by the

National Committee for Quality Assurance for hiring and contracting with physicians, other providers and health care facilities. Health plans should not discriminate against providers who treat a disproportionate number of patients with expensive or chronic medical conditions.

16. Provider Reimbursement Incentives.

Neither health plans nor provider groups should use payment methodologies that directly encourage providers to over treat patients or to limit medically necessary care. General information about the types of reimbursement methodologies used for providers should be disclosed.

17. Quality Assurance.

All health plans should be subject to comparable comprehensive quality assurance requirements. Standards should provide for external review of the quality of care, conducted by qualified health professionals who are independent of the plan and accountable to the appropriate regulatory agency.

18. Utilization Management.

Utilization management activities of health plans should be subject to appropriate regulation, including requirements to use appropriately licensed providers to evaluate the clinical appropriateness of adverse decisions. Health plans should make timely and, if necessary, expedited decisions, and give the principal reasons for adverse determinations and instructions for initiating an appeal. Health plans should be prohibited from having compensation arrangements for utilization management services that contain incentives to make adverse review decisions.

It seems likely that more of these sort of guidelines will be developed by consumers and other groups interested in protecting the public.

A Final Word About Ethical Issues

The choices and decisions of health care providers are inevitably shaped by the institutional and cultural context in which the providers operate. Institutional arrangements embody certain cultural messages about what constitutes appropriate behavior. Policies and customs can help to clarify responsibilities and support ethical decision making, or they can exacerbate conflicts of interest, create incentives for unethical choices, and undermine accountability. Because ethical decision making is so important to healthy human relationships, institutional arrangements that send contradictory messages about what is appropriate, or that undermine or discourage ethical decision making, can be socially destructive. We believe that one of the responsibilities of health care providers is to use their influence, in collaboration with others, to create a health care system and institutions within that system that will minimize unnecessary ethical conflicts of interest and clarify priorities.

A Call To Action

The first section of the appendix that follows this chapter is devoted to you, the reader, developing a plan for action. As you have interacted with this book, hopefully not in a single reading, we hope we have stimulated some thought and possible some ideas to help you address the challenges of managing a rehabilitation practice. Use the action planning form to begin your transformation and that of your department. Return to Chapter 1 - Self Assessment regularly and update the information you completed when you started this book.

Use this book, use your knowledge and talents, and develop sustainable, meaningful rehabilitation programs and practices. You owe it to your organization, your colleagues, your patients and yourself. Good Luck.

Developing a Plan for Action

Complete this section after reviewing or reading this book.

What New Skills Will You Need to Thrive in a Managed Care Environment?

What Will Need to Change in Your Organization to Thrive in a Managed Care Environment?

What Actions Will You Need to Take to Acquire These New Skills?

Who Will Need to Assist and Support You and Your Organization as You Take Actions to Acquire the New Skills for Managed Care?

Onward to Success in Managed Rehabilitation.

Glossary of Key Terms

Ambulatory Surgery - Surgery performed on a non-hospitalized patient; patient goes home the same day as the surgery.

Ambulatory Visit Group (AVG) - Similar to DRGs, except outpatient rather than inpatient hospital care.

Basic Benefits - A set of "basic health services" specified in the member's certificate and those services required under applicable federal and state laws and regulations.

Benefit Package - The list of covered services an insurance company/HMO/PPO offers to a group or individual.

California Relative Value Studies (CRVS) - A coded listing of physicians services with unit values to indicate the relativity of charges to the median.

Capitation - A per-member, monthly payment to a provider that covers contracted services, and is paid in advance of the delivery of the service. In essence, a provider agrees to provide specified services to Health Maintenance Organization members for this fixed, predetermined payment for a specified length of time (usually a year), regardless of how many times the member uses the service.

Case Management - The comprehensive management of a member's health problems wherein the chronically ill or otherwise impaired individual may require long term and/or costly care.

Catastrophic Case - A catastrophic case is any medical condition where total cost of treatment (regardless of payment source) is expected to exceed an amount designated by the Health Maintenance Organization contract with the medical group.

COBRA - A federal law which permits many people who lose eligibility under a group health plan to continue that coverage without lapse.

Coinsurance - The percentage of costs of medical care that a patient pays himself. Coinsurance rates generally hover in the 10 percent to 20 percent range. Coinsurance and deductibles are most commonly found in indemnity, fee-for-service insurance and the Preferred Provider Organization market. Their absence in the Health Maintenance Organization arena is one of the strong marketing appeals of Health Maintenance Organizations.

Commercial Plan - Refers to the benefit package an insurance company/HMO/PPO offers to employers. This is distinguished from a senior plan which is offered to Medicare beneficiaries.

Concurrent Review - A method of reviewing patient care, during hospital confinement, to validate the necessity of current care and to explore alternatives to inpatient care.

Continuity of Care - The degree to which the care of a patient from the onset of illness until its completion is continuous, that is without interruption.

Continuum of Care - A range of medical, nursing treatments and social services in a variety of settings

that provides services most appropriate to the level of care required. For example, a hospital may offer services ranging from nursery to a hospice.

Conversion Factor - A dollar amount for one base unit in the relative value scale (RVS). The price to be paid to the provider for a given service equals the relative value of the service multiplied by the dollar amount of the conversion factor. For example, a blood sugar determination might have a relative value of 5.0, and the conversion factor might be \$5.00. The "price" of the blood sugar determination would therefore be \$25.00.

Conversion Plan - A member's group plan is canceled; the member opts to continue coverage under an individual plan.

Coordination of Benefits - A process wherein if an individual has two group health plans, the amount payable is divided between the plans so that the combined coverage amounts to, but does not exceed, 100 percent of the charges.

Co-Payment - A supplemental cost-sharing arrangement in which the Health Maintenance Organization enrollee pays, to the provider, a specified amount for a specific service.

Corporate Practice of Medicine - State laws prohibiting lay people, organizations and corporations from directly or indirectly practicing medicine. They are designed to ensure that those making decisions about the provision of medical services will not be subject to commercial exploitation.

Credentialing - The process of determining eligibility for hospital, Physician Hospital Organization, of other medical staff membership, and privileges to be granted to physicians. Credentials and performance are periodically reviewed, which could result in a doctor's privileges being denied, modified, or withdrawn.

Custodial Care - Care provided primarily to assist a patient in meeting the activities of daily living, but not care requiring skilled nursing services.

Customary and Reasonable - Refers to a fee which falls within a common range of community fees.

Days Per Thousand (per 1,000) - A measurement of the number of days of hospital care used in a year per 1,000 Health Maintenance Organization members.

Deductible - A set dollar amount that a person must pay before insurance coverage for medical expenses can begin.

Durable Medical Equipment - Equipment which meets the following criteria:

- A) can withstand repeated use; B) is primarily and customarily used to serve a medical purpose;
- C) generally, is not useful to a person in the absence of illness/injury; D) is appropriate for home use.

Economic Credentialing - This means taking a physician's economic behavior into account (i.e. tests ordered, hospital bed days, outcomes) in deciding upon medical staff appointment or re-appointment.

Effective Date - The date on which the Health Plan Agreement goes into effect.

Eligibility Guarantee - An assurance of reimbursement to the medical group for services/goods provided to a member who subsequently is found to be ineligible for benefits.

Emergency Services - Services provided in connection with an unforeseen acute illness or injury requiring immediate medical attention.

Encounter - A member visit to the medical group with the intent of seeing a health care provider. There may be a variety of services performed at an encounter: a brief office visit, EKG, lab test, and an immunization.

Enrollee - Synonymous with member. A person eligible to receive, or receiving, benefits from a Health Maintenance Organization or insurance policy. Includes both those who have enrolled or "subscribed" and their eligible dependents.

Enrollment - The number of members in a Health Maintenance Organization. The number of members assigned to a physician or medical group providing care under contract with a Health Maintenance Organization. Also, the process by which a health plan signs up individuals or groups as subscribers.

Enrollment Area - The geographic area within a designated radius (varies by HMO) of the PMG selected by the subscriber.

Enrollment Protection - The practice of a Health Maintenance Organization to protect its contracted medical groups against part or all losses incurred for physician services above a specified dollar amount while caring for the Health Maintenance Organization's enrollees. Also referred to as stop-loss or reinsurance.

Exclusive Provider Organization (EPO) - A health plan in which patients must go to a participating provider or receive no benefit. This is a cross between a Health Maintenance Organization and a PPO (See preferred provider organization). Like a Preferred Provider Organization doctors typically are paid on a fee-for-service basis and aren't at risk. However, patients have less freedom to go out of network than with a Preferred Provider Organization.

Federally Qualified Health Maintenance Organization - An HMO that meets certain federally stipulated provisions aimed at protecting consumers: e.g., providing a broad range of basic health services, assuring financial solvency, and monitoring the quality of care. Health Maintenance Organizations must apply to the federal government for qualification. The process is administered by the Office of Prepaid Health Care of the Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS).

Fee - A charge or price for professional services.

Fee-For-Service (FFS) - A system of payment for health care whereby a fee is rendered for each service delivered. This traditional method contrasts with that used in the prepaid sector where services are covered by a fixed payment made in advance that is independent of the number of services rendered.

Fee Schedule - A listing of charges or established benefits for specified medical or dental procedures.

Gatekeeper - The primary care physician who must authorize all medical services, (e.g., hospitalizations,

diagnostic work-ups, and specialty referrals) for a member.

Group Model - In a group model Health Maintenance Organization, the HMO contracts with a group of physicians, which is paid a set amount per patient to provide a specified range of services. The group of physicians determines the compensation of each individual physician, often sharing profits. The practice may be located in a hospital or clinic setting.

Guidelines - You may hear these referred to as practice parameters. clinical practice guidelines or protocols. These are statements by authoritative bodies as to the procedures appropriate for the physician to employ in making a diagnosis and treating it. The goal of guidelines is to change practice styles, reduce inappropriate and unnecessary care and cut costs.

Health Care Financing Administration (HCFA) - The agency within the Department of Health and Human Services which administers federal health financing and related regulatory programs, principally the Medicare, Medicaid, and Peer Review Organization.

Health Maintenance Organization (HMO) - A legal corporation that offers health insurance and medical care. Health Maintenance Organizations typically offer a range of health care services at a fixed price (see capitation).

Types of Health Maintenance Organizations:

- Staff Model -- Organization owns its clinics and employs its docs.
- Group Model -- Contract with medical groups for services.
- IPA Model -- Contract with an Independent Practice Association that in turn contracts with individual physicians.
- Direct Contract Model -- Contracts directly with individual physicians.
- Mixed Model -- Members get options ranging from staff to Independent Practice Association models.

Health Plan - A generic term to refer to a specific benefit package offered by an insurer. Also used to pertain to the insurer; e.g., "I signed up for the Blue Cross health plan."

Hospice Services - Services to provide care to the terminally ill and their families.

Hospital Day - A term to describe any twenty-four hour period commencing at 12:00 a.m., or 12:00 p.m., whichever is used by a hospital to determine a hospital day, during which a patient receives hospital services at the hospital.

Incurred but not Reported (IBNR) - A cash reserve set up by a payer to cover claims that have been filed but not officially reported as paid.

Independent Practice Association (IPA) - Contracts with individual physicians who see Health Maintenance Organization members, as well as their own patients, in their own private offices. It is the ability of IPA physicians to see both Independent Practice Association and private patients in their own offices that principally differentiates an IPA from a group or staff Health Maintenance Organization. Physicians in an Independent Practice Association are paid either on a capitation or a modified fee-for-service basis.

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-M) - The World Health Organization's ninth edition of its book used widely for hospital diagnoses. A 10th version recently

has been released. You may read about fee structures that are designed along the lines of ICD-9 codes.

Knox-Keene Act - California legislation (1975) amending the Health and Safety Code that licenses Health Maintenance Organizations separately from insurance companies. Provides for regulation by the corporations Commissioner.

Managed Care - A relatively new term coined originally to refer to the prepaid health care sector (e.g., HMOs) where care is provided under a fixed budget and costs are therein capable of being "managed". Increasingly, the term is being used by many analysts to include Preferred Provider Organizations and even forms of indemnity insurance coverage that incorporate preadmission certification and other utilization controls.

Management Services Organization (MSO) - A management entity owned by a hospital, physician organization, or third party. The Medical Service Organization contracts with payers and hospitals/physicians to provide services such as negotiating fee schedules, handling administrative functions, and billing and collections.

Medically Necessary - A term used to describe the supplies and services provided to diagnose and treat a medical condition in accordance with the standards of good medical practice and the medical community.

Medicare - The federally financed hospital insurance system (part A) and supplementary medical insurance (part B) for the aged created by the 1965 amendment to the Social Security Act.

Medicare Select - A type of Medicare supplement insurance which has lower premiums in return for a limited choice of beneficiaries: they will use only providers who have been selected by the insurer as "preferred providers". Also covers emergency care outside the preferred provider network.

Medicare Supplement Insurance or "Medigap" - It provides additional individual benefits under Medicare. There are 10 standardized Medigap plans with specific packages of benefits.

Member - A person eligible to receive, or receiving, benefits from a Health Maintenance Organization or insurance policy. Includes both those who have enrolled or "subscribed" and their eligible dependents.

Messenger Model - A method of setting fees for loose, non-risk bearing Managed Care Organizations such as Independent Practice Associations or Physician Hospital Organizations. A designated agent must act as a "messenger", shuttling individual physician information to the payer and vice versa. This method meets the criteria of antitrust laws that bar physicians from sharing any practice data or fee information.

Medically Unnecessary Days - MUD - A term used to describe that part of a stay in a facility, as determined by a case manager, as excessive to diagnose and treat a medical condition in accordance with the standards of good medical practice and the medical community. Excessive may be because stay was too long or appropriate is available in a less costly or more efficient setting.

Open Enrollment - The annual period during which people in a "dual choice" health benefits program can choose among the two (or more) plans being offered. Also the period during which a federally qualified Health Maintenance Organization must make its plan available without restrictions to individuals who are not part of a group.

Outcome - This term has been used to mean different things to different people. It can refer to the

following:

- Changes in birth and death rates for a global population, for example, residents of a state.
- The "outcome" or finding of a given diagnostic procedure.
- The results for a patient after care, for example, how long it took to restore the patient's ability to walk or to work.

Out-of-Area - Refers to the treatment given a Health Maintenance Organization member outside the geographical limits of his own Health Maintenance Organization. The coverage generally is restricted to emergency services.

Per Diem Cost - Cost per day; hospital or other institutional cost for a day of care.

Per Member Per Month (pmpm) - Generally used by Health Maintenance Organizations and their medical providers as an indicator of revenue, expenses, or utilization of services per member per one month period; e.g., "we receive a capitation payment of \$30 per member per month."

Per Member Per Year (pmpy) - Generally used by Health Maintenance Organizations and their medical providers as an indicator of revenue, expenses or utilization of services per member per year.

Physician-Hospital Organization (PHO) - It is owned jointly by a hospital and a physician group. The PHO, in turn, contract with hospitals and physicians for the delivery of services to payers under contract to the Physician Hospital Organization. It can also provide management services and perform other services typically associated with a Medical Service Organization.

Physician Organization (PO) - A group of physicians banding together, usually for the purpose of contracting with managed care entities or to represent the physician component in a Physician Hospital Organization.

Point of Service Plan - A Health Maintenance Organization plan which allows the member to pay little or nothing if they stay within the established Health Maintenance Organization delivery system, but permits member to choose and receive services from an outside doctor, any time, if they are willing to pay higher copayments, deductibles and possibly monthly premiums. Also called an open-ended plan.

Preferred Provider Organization (PPO) - A system in which a payer negotiates lower prices with certain doctors and hospitals. Patients who go to a preferred provider get a higher benefit -- for example, 90 percent or 100 percent coverage of their costs -- than patients who go outside the network.

Premium - A predetermined monthly membership fee that a subscriber or employer pays for the Health Maintenance Organization coverage.

Primary Care - Physicians who are predominantly primary care doctors include general or family practitioners, internists, pediatricians and sometimes OB/GYN doctors.

Prospective Review - A method of reviewing possible hospitalization, prior to admission, to determine necessity of confinement, outpatient alternatives and estimated reasonable length of stay.

Quality Management - A formal set of activities to assure the quality of services provided. Quality management includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

Referral Authorization - A verbal or written approval of a request for a member to receive medical services or supplies outside of the participating medical group.

Referral Physician - A physician who has a patient referred to him by another Source for examination, surgery, or to have specific procedures performed on the patient, usually because the referring source is not prepared or qualified to provide the needed service.

Referring Physician - A physician who sends a patient to another source for examination, surgery, or to have specific procedures performed on the patient, usually because the referring physician is not prepared or qualified to provide the needed service.

Reinsurance - The practice of a Health Maintenance Organization or insurance company of purchasing insurance from another company to protect itself against part or all the losses incurred in the process of honoring the claims of policyholders. Also referred to as "stop loss" or "risk control insurance".

Relative Value Scale (RVS) - RVS is the compiled table of relative value units (RVUs), which is a value given to each procedure or unit of service. As payment systems, RVS is used to determine a formula which multiplies the RVU by a dollar amount, called a converter (see conversion factor).

Resource Based Relative Value Scale (RBRVS) - A method of determining physicians' fees based on the time, training, skill and other factors required to deliver various services.

Retrospective Review - A method of reviewing patient care, after hospital discharge, to determine quality, necessity and appropriateness of care.

Risk - Refers to finances used for providing patient care. For example, an HMO which offers prepaid care for a given premium is "at risk" because it must provide care within the premium funds available.

Risk Sharing - The process whereby an HMO and contracted provider each accept partial responsibility for the financial risk and rewards involved in cost effectively caring for the members enrolled in the plan and assigned to a specific provider.

Senior Plan - Refers to a benefit package offer by an HMO or other insurer to beneficiaries eligible for Medicare parts A & B.

Service Area - The geographic area served by an insurer or health care provider.

Silent PPOs - You may call these voluntary Preferred Provider Organizations, wrap-around Preferred Provider Organizations or blind Preferred Provider Organizations. They act like brokers by selling your discounts to parties that don't guarantee you volume. For example, a Preferred Provider Organization that you contract with sells your discounts to an insurer, which applies the discounts to your bills.

Supplemental Benefits - Benefits contracted for by an employer group which are outside of, or in addition to, the basic health plan.

Stop-loss - The practice of an HMO or insurance company of protecting itself or its contracted medical groups against part or all losses above a specified dollar amount incurred in the process of caring for its

policyholders. Usually involves the Health Maintenance Organization or insurance company purchasing insurance from another company to protect itself. Also referred to as reinsurance.

Subscriber - An individual meeting the health plans' eligibility requirement, who enrolls in the health plan and accepts the financial responsibility for any premiums, copayments, or deductibles.

Tertiary Care - Medical care requiring a setting outside of the routine, community standard; care to be provided within a regional medical center having comprehensive training, specialists, and research training.

Third Party Administrator (TPA) - An organization that administers health care benefits, mostly for self-insured employers. Services may include claims review and claims processing.

Third-Party Payment - A term used to describe the monetary reimbursement for medical services from someone other than the member or the member's insurance plan.

Utilization - The frequency with which a benefit is used -- for example 3,200 doctors office visits per 1,000 Health Maintenance Organization members per a year. Utilization experience multiplied by the average cost per unit of service delivered equals capitated costs.

Utilization Review - Evaluation of the necessity, appropriateness, and efficiency of the use of medical services and facilities. Helps insure proper use of health care resources by providing for the regular review of such areas as admission of patients, length of stay, services performed and referrals.

Withhold - The portion of the monthly capitation payment to physicians withheld by the Health Maintenance Organization until the end of the year or other time period to create an incentive for efficient care. The withhold is at risk; i.e., if the physician exceeds utilization norms, he does not receive it. It serves as a financial incentive for lower utilization.

The Productive Therapist

Rate Yourself as The Productive Therapist - Now and Where You Plan to Be.

Score yourself on each of the following characteristics.

Put a circle indicating where you are now and an X where you want to be.

Example

I am as productive as I can be without lowering the quality of my patient care.	1	2	<input type="checkbox"/>	X	4	5
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Handling Interruptions Throughout My Day

I have systems to limit interruptions throughout my day	1	2	3	4	5
I notify the office which situations or calls warrant interruptions	1	2	3	4	5
I schedule specific times to return calls	1	2	3	4	5
I schedule specific times to receive calls	1	2	3	4	5
I share clinical techniques only for professional reasons - never for social reasons	1	2	3	4	5
I am able to focus on my clinical care. I am not easily distracted in the clinic	1	2	3	4	5

Scheduling and Organizing My Day

I schedule my patients in regular time slots when possible	1	2	3	4	5
I am aware of my schedule for the day	1	2	3	4	5
I anticipate discharges and plan accordingly	1	2	3	4	5
I have a system to prioritize my tasks, e.g. daily planner	1	2	3	4	5
I prepare at the end of each day for the next day's activities	1	2	3	4	5
I prepare at the end of each morning for my	1	2	3	4	5

afternoon activities

Structuring My Initial Patient Interactions

I explain the importance of attendance to each patient at the time of the initial evaluation	1	2	3	4	5
I do not give patients Apermission@ to cancel appointments or fail to show	1	2	3	4	5
I help my patients develop a mental picture of what success in therapy will be for them	1	2	3	4	5
I work with my patients as a partner to them to develop mutual goals	1	2	3	4	5
I negotiate agreement and commitment to our mutual goals with my patients	1	2	3	4	5
I emphasize patient responsibility and the need for a team effort for optimal recovery	1	2	3	4	5

Structuring My Ongoing Patient Interactions

I am committed to patient education	1	2	3	4	5
I use educational handouts, demonstrations, and audiovisuals to make my patient teaching more effective	1	2	3	4	5
I personalize handouts for each patient by highlighting those areas most important for that patient	1	2	3	4	5
I back up verbal instruction with written materials	1	2	3	4	5
I determine my patient=s commitment to completion of home programs and to following recommendations	1	2	3	4	5
I ask my patients about their actual success in performing home programs and following recommendations	1	2	3	4	5

I use simple language and avoid jargon and multi syllable words in my explanations to my patients	1 _____ 2 _____ 3 _____ 4 _____ 5
I remind myself to listen more and talk less with my patients	1 _____ 2 _____ 3 _____ 4 _____ 5
I work to improve my listening skills, including maintaining good eye contact with my patients	1 _____ 2 _____ 3 _____ 4 _____ 5

My Treatment Philosophy

I emphasize what works rather than any specific set of clinical techniques	1 _____ 2 _____ 3 _____ 4 _____ 5
I emphasize the patient=s role in their recovery	1 _____ 2 _____ 3 _____ 4 _____ 5
I define quality from the patient=s perspective, not mine	1 _____ 2 _____ 3 _____ 4 _____ 5
I define good therapy as what produces the best and quickest results	1 _____ 2 _____ 3 _____ 4 _____ 5
I use a tiered approach to patient care, starting with the least costly, least risky treatments when I am unsure of a single, best course of action	1 _____ 2 _____ 3 _____ 4 _____ 5

Meetings

I attend meetings on time	1 _____ 2 _____ 3 _____ 4 _____ 5
I request timed agendas for meetings that I attend	1 _____ 2 _____ 3 _____ 4 _____ 5
I participate in meeting effectiveness critiques to improve our meeting processes	1 _____ 2 _____ 3 _____ 4 _____ 5

My Documentation

I complete my notes while I am with the patients	1 _____ 2 _____ 3 _____ 4 _____ 5
I use documentation technology to my benefit, not to my detriment	1 _____ 2 _____ 3 _____ 4 _____ 5

I keep up with my notes, I rarely fall significantly behind

1 _____ 2 _____ 3 _____ 4 _____ 5

My Delegation Style

I delegate routine or repetitive care

1 _____ 2 _____ 3 _____ 4 _____ 5

I communicate with support staff to receive feedback on the patient=s response to treatment

1 _____ 2 _____ 3 _____ 4 _____ 5

I use a decision process to decide what, when and to whom to delegate

1 _____ 2 _____ 3 _____ 4 _____ 5

Planning Sheet

Section	Actions Needed to Improve	Who Will Help	Time Frame
Handling Interruptions			
Scheduling and Organizing			
Initial Patient Interactions			
Ongoing Patient Interactions			
Treatment Philosophy			
Meetings			
Documentation			
Delegation Style			

If there is a difference between where you think you are now and where you want to be, you need to change some of your activities and/or attitudes to reach what you have identified as where you want to be. These are your targets, no one else=s.

Developing a plan to bridge the gap in where you are and where you want to be.

What actions will you take to change your behaviors and skills as a productive clinician? List them here.

When do you want to accomplish this? Be specific.

Who will help and support you as you make these changes?

Good Luck as you become The Productive Therapist.

