# Pressure on Providers: Retooling to Deal with the Squeeze on Coverage

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# Increased Pressure . . .

- Financial health of payers, particularly regional nonprofits
- Adequacy of premium rates and the impact on contractual negotiations
- Growing shift to Medicaid and Medicare managed care products
- Continuing downward compression of reimbursement

# . . . And Becoming More Complicated

- Increasing:
  - rate of denials
  - authorization requirements
  - level of care reviews
  - number of audits
  - delays in appeal resolution
- Out-of-state issues
- Medicare Advantage
  - Par- and non-par

# Immediate Marketplace Concerns

## Before Repeal Discussion

- Growth in high-deductible products
- Growth in deregulated products (ASO and ASO-like products)
- Growth in closed panel, narrow network options
- Continued pressure on premium growth and efforts to contain cost

## After (in addition to above)

- Subsidies
- No individual mandate
- No regulatory oversight (e.g., Medicare Advantage)
- No transparency
- State law won't apply
- Dynamics: increased bad debt and collection concerns, battles over coverage, payment, and resources devoted to them

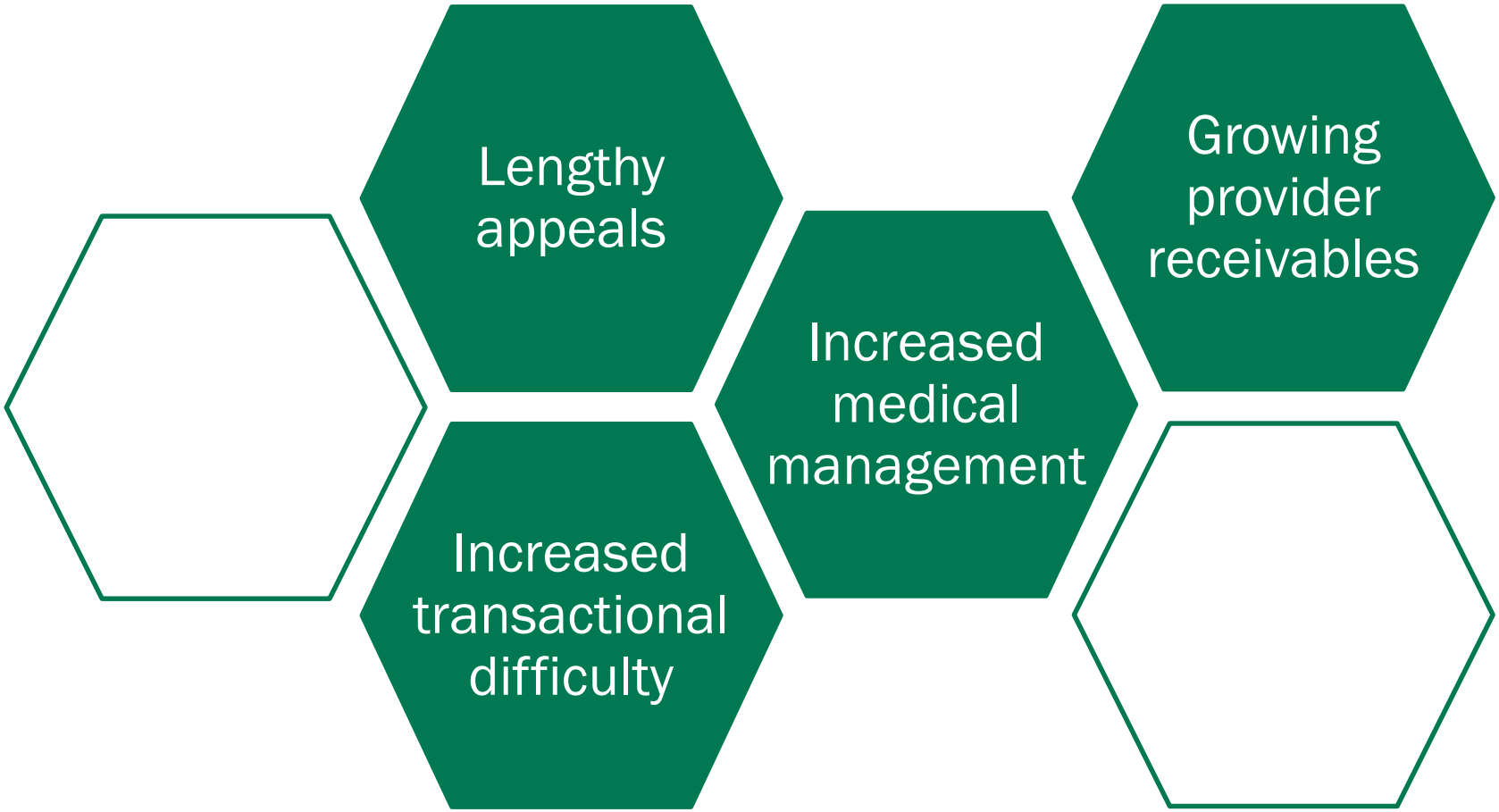
# Post- BCRA & AHCA: Factors Causing Uncertainty

- Cost-sharing subsidies: Funded or not, and for how long?
- Will the Market Stabilization Rule stabilize the markets?
- Is it possible to create more choice without undermining comprehensive coverage, guaranteed issue, and community rating?
- Does New York have at least temporary insulation?
- Will market erosion occur through the purchase of non-regulated products, or through the sale of insurance across state lines?
- Will employer-sponsored coverage be impacted (e.g., annual and lifetime limits)?
- What administrative actions will HHS take and what will their impact be?

# Denials Management Strategy to Inform Contracting

1. Assemble a denials management team
2. Limited resources must be used in a targeted way
3. Identify internal risk points
4. All denials should be used for QA purposes or should be appealed
5. Set expectations for payers
6. Negotiate fair contracts
7. Marry experience in the trenches with the negotiation process
8. Assess negotiating strengths and weaknesses with particular payers
9. Identify and eliminate “fictions”
10. Make more upstream fixes

# New Challenges



# Why?

- Retrenching?
  - "We were always right"
- Financial challenges?
  - Responding to Wall Street pressure
- Post-ACA Fall-Out/Reform Fatigue
  - Viability of Exchange market
  - Increased taxes and costs
  - Push for more government control over rates

# National and Statewide Themes

- Mergers & Consolidations
- Financial Gains & Losses
- Exiting Exchange & other Government lines of business
- Narrow and Tiered Networks
- Shifting away from fully insured business to ASO/TPA/ERISA-Preempted Models

# Three-Bucket Strategy

## 1. Shared Agenda with Payers: Common Ground

- Health Republic, Prior Approval and premium adequacy
- Regulatory barriers
- Ensure plans do not abandon markets
- Impact of insurance across state lines

## 2. Better Partnerships: Shared views of payment and coverage models

- Penetration and ROI from VBP, shared risk contracts has not really occurred
- Lead systems and plans to new levels of collaboration (SWAT), negotiations with plan associations and major payers
- Introduce best practices from successful models

## 3. Challenging Payers and Helping Members Problem Solve: Increased pressure, increased disputes

- Uptick in contract disputes, clinical denials, claims processing and payment issues
- Critical high-level skills in revenue cycle and contract negotiation for members
- With less federal regulatory oversight, must be resolved by the parties
- Will get larger as more high-deductible, less transparent, less regulated, more limited network or scope of coverage products become more prevalent

# Managed Care Principles

1. Insurance products should be transparent and easily identifiable to providers
2. Tiering and steering is permissible only if transparent and negotiated fairly
3. Coding reductions should not be allowed in the absence of clinical review
4. Authorized care should never be subject to administrative denials, but only to medical necessity reviews
5. Paying “wrong” and relying on the provider to appeal for correct payment is unfair
6. Audits should not be permitted to re-adjudicate medical necessity
7. Audits should be limited in size and scope that only place reasonable burdens on providers

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