Dynamic Chiropractic

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Managed Care: Is the Pie Shrinking, or Are Appetites Just Increasing?

Chiropractic independent practice associations (IPAs) began as an effort to include chiropractic in preferred provider organizations (PPOs), and eventually the health maintenance organizations (HMOs) followed suit. Chiropractic needed an advocate for its inclusion, and an assurance to the medical managed care companies that chiropractic could be added to the benefit safely without added administrative headaches for the managed care organizations (MCOs). Individuals or small groups of chiropractors, of course, did not have the same clout with health plans as large, state wide chiropractic IPAs, which could offer enough chiropractors to serve the membership of a health plan and handle the administration of the benefit. The chiropractic IPAs were necessary for chiropractic to establish itself as a legitimate part of the managed care benefit plans.

As managed care evolved and standards set by state regulatory agencies and accrediting agencies (such as the National Committee for Quality Assurance and American Accreditation Health Care Commission) became increasingly more sophisticated, chiropractic IPAs were necessary to coordinate the contracting, credentialing, utilization review, and quality improvement activities that would otherwise be administered uniquely by each MCO. So where do things stand today?

Much of this can be summed up with the saying that as the pie gets smaller, the table manners get worse. The current state of affairs has evolved into two sets of bidding wars. One battle exists between the health plans and the chiropractic IPAs/HMOs, whereby the health plans are willing to pay less in capitation rates for the chiropractic benefit than five years ago. The other contest, if you will, exists between the two major chiropractic IPAs/HMOs in California that are scrambling to retain the health plan contracts they currently have and obtain the contracts of their competitors as well. Unfortunately, to offer the chiropractic benefits at the rates the health plans are willing to pay, the IPA chiropractic fee schedules have taken a hit.

To understand how the California chiropractic IPA/HMO fees ended up where they are today, one must look back at the last several years. When Landmark began offering chiropractic benefits in the Northeast in 1998, the fee for the manipulation service had been viewed by many practitioners as too low. As such, early in the year 2000, the fee paid by Landmark for the chiropractic visit was rolled up into one so that all practitioners would receive the same reimbursement, regardless of the number or type of services provided. This is known as a "global fee" and was a way to give the "manipulation-only" chiropractors in the Northeast a raise, while still working within the budget of the per-member-per-month (PMPM) fees the health plans pay for the chiropractic benefit.

However, the global fee schedule that was arguably more compatible with practices in the Northeast, where the use of adjunctive therapies is less common, was not equally compatible with practice in California, where physiotherapy as an adjunct to manipulation is almost universal. The new global fee schedule was applied to all Landmark HMO contracts, and a great many Landmark practitioners in California ended up with a reduction in fees for services provided to those members. Now ASHP has implemented a fee schedule in California not entirely dissimilar from Landmark's. ASHP asserts that a "competitor" in California approached ASHP's health plan clients with lower rates, forcing ASHP to lower its capitation rates to its California health-plan clients,

necessitating a reduction of the chiropractic fee schedule as a result of lost revenues. The reason that there was not a huge hue and cry when Landmark changed its fee schedule earlier this year is simple: In California, Landmark does not represent nearly the same volume of patients as ASHP.

The challenge for chiropractic IPAs is to make the case for how they remain relevant and necessary to DCs in California. With chiropractic being offered by nearly every health plan in the state, it is difficult for the IPAs to bring a greater volume of patients to their panels. Instead, the IPAs must primarily compete against each other for market share. The IPAs still take on the coordination of contracting, credentialing, utilization review and quality improvement activities. However, the chiropractic IPAs are challenged with demonstrating to their chiropractic panels that the value of their administrative services is still favorably balanced by the reimbursement offered and the time required to participate in the pre-authorization, recredentialing and quality improvement systems. In short, they must demonstrate that the piece of the health- care-dollar-pie that they use is money well spent.

The primary concern for the profession today is how to ensure that this "pie" is divided equitably. The logical starting place for this assessment is with the health plans. After all, they are the ones dictating to the IPAs/HMOs how much they are willing to pay in PMPM for the chiropractic benefit. However, the capitation rate that the health plan pays to the chiropractic IPA/HMO may differ, in some cases significantly, from the PMPM rate that the health plan is receiving from the employer group for that chiropractic benefit. In other words, the health plan typically charges the employer group more in PMPM than what it pays to the chiropractic IPA/HMO to administer the benefit and pay the claims. While the health plan bears some administrative expenses in overseeing the IPA/HMO and assisting members with the chiropractic benefit, it seems that those costs should be relatively minor. It would be interesting to know whether any decreases in rates paid by the health plans to ASHP were passed along by the health plans to the employer groups with the chiropractic benefit. Or could the health plans be using the difference to offset losses in their medical costs without having to lower capitation to their medical groups?

In all fairness, this same scenario holds true for the chiropractic HMOs when they contract directly with an employer group A instead of the health plan. What the chiropractic specialty HMOs are able to charge an employer group in PMPM for the chiropractic benefit is generally much greater than what they receive under capitation from a health plan; as in this case, the chiropractic HMO is not sharing any of the PMPM with a health plan. The number of lives enrolled directly with the chiropractic HMOs in California has been relatively low, however, and the reduced fee schedule has been applied to these patients, despite that the PMPM revenues for these lives have presumably not decreased.

I suggest a more sophisticated reimbursement system that rewards high quality, efficient chiropractors that are also very accessible to members. The flat fee, either per diem or global, does just the opposite, and essentially pits the practitioners against the IPA. Worse yet, as those fees drop, the schism becomes greater. The situation is not irreparable, but it calls for creative solutions from the chiropractic IPAs/HMOs, if they are to emerge from this difficult time with a restoration of their *raison d'être.*

Caroline Iverson,DC
Davis, California

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