Dynamic Chiropractic

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Navigating the New Era of Reimbursement

WHICH MODEL IS RIGHT FOR YOUR PRACTICE?

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Chiropractors and indeed the entire health care community are searching for ways to reduce costs and improve patient outcomes. New reimbursement models are being analyzed by the federal government and private insurance payers. While claims have been made that both payers and providers are being considered in the payment process, all of the proposed models have potential for risk as well as reward. Let's take a look at some of the new models of reimbursement and evaluate which options will be winners or losers for chiropractors.

Many chiropractors are concerned about how the changes in reimbursement will impact their practice. I am often asked for advice on how to navigate through the many new models of reimbursement that are emerging. While the path ahead may be a wandering one, the path behind is sure. The days of fee-for-service reimbursement as the profession has known it are numbered. The movement toward a value-based system of payment has many forms, but the new normal will be a model that assigns value to care based upon quality.

The new reimbursement models are very different from those of the past decade. The ability to capture and analyze vast quantities of health care data brought about by the adoption of the electronic health record is improving payers' ability to assign and adjust risk. In addition, compared to the managed care models for cost-containment forced on providers by payers in the past, many of the new reimbursement models are being innovated by providers themselves.

The Patient-Centered Medical Home

According to the Agency for Healthcare Research and Quality, a patient-centered medical home (PCMH) is not a single place, but a model for organizing and delivering comprehensive and coordinated health care by a team of providers who are linked in a virtual network composed of many multiple types of health care providers that may include chiropractors.

As a provider within a PCMH, you will receive some form of up-front payment in anticipation that you will use the money to achieve savings down the road. Both the amount of the payment and the expectations of savings attached to it are variables. If you receive a small payment with the expectation that you will achieve significant changes in savings while maintaining quality, you should be aware that you might find your practice unable to meet overly aggressive expectations.

It is also important to note that while Medicare may pay you money up front, there is no guarantee that the amount will not decrease in the year ahead. If your practice hires new staff members in order to meet the expected volume of care, your up-front payment may not be sufficient for you to employ your new hires if the funding decreases.

The risk of this possibility may keep some practices from investing enough to achieve the lasting quality-based improvements being asked of them.

Today, most of the PCMH funding is through pilot programs that have no guarantee they will last. If the pilot program you are involved with comes to an end, not only will there be an impact on your cash flow; you may also find yourself in the position of having to lay off a valued employee.

The good news is that even while many PCMHs are demonstration projects, it appears that they are attracting significant numbers of patients. This model may be the direction in which the reimbursement world is going.

Action Step: Visit the Foundation for Chiropractic Progress website and download the white paper, "The Role of Chiropractic Care in the Patient-Centered Medical Home" from the Industry News

section.

Bundled Payments

Bundled payment, also known as episode-based payment, is defined as the reimbursement of health care providers on the basis of expected costs for treating a specific condition over a period of time. It is similar to fee-for-service inasmuch as you are being paid to provide a specific service. The difference is you are being paid for all of the work that goes into treating a specific condition, not for each individual visit.

For example, if you see a patient for a lower back complaint and it requires an examination, multiple X-rays, chiropractic adjustments, passive and active therapy, in the episode-based bundled model payment of care, you would receive one payment to cover all of the work that went into caring for the patient's back. The incentive in this model is to reduce the number of procedures performed (for example, the number of X-rays taken) without reducing the quality of care. The broadest goal would be to lower costs, save the patient time and possibly exposure to radiation, while providing the necessary care.

Success in the bundled care model of reimbursement requires you to analyze whether or not it is the right deal for you. This means you must have access to the most accurate and current data. However, in many instances, you may be required to sign a contract based upon data that is several years old. Your cost to deliver the required services in the current market may not resemble what it was just a few years ago.

You can protect yourself by negotiating "risk corridors" so if your actual costs turn out higher than you contracted for, you may only be responsible for a small part of the total risk.

Action Step: Visit the Congress of Chiropractic State Associations website for your state association's contact information. Contact your association for information on insurance payers' practices in your state.

Promoting Shared Savings: Accountable Care Organizations

The shared savings model or accountable care organization (ACO), is based on the philosophy of "all for one and one for all," including both the payers and providers. ACOs are groups of doctors, hospitals and other health care providers who come together voluntarily to provide coordinated care to their patients.

As a provider in an ACO, you split the savings on patient care with the insurer and receive a bonus if you can save money. However, this model is a dual-edged sword and you may end up responsible for a percentage of the costs if your care goes over budget. There are multiple factors that may be out of your control and can cause this to occur.

The ACO model could be a challenging option, as it requires your practice to generate savings without changing its fee-for-service payments. Most ACOs are also based on minimum savings percentages typically higher for smaller practices, which can experience greater fluctuations in the cost to deliver care than larger group practices and hospitals. This threshold may be difficult for your practice to hit and you may find yourself left out of the ACO's year-end savings bonus.

Finally, the tracking of shared savings is on a multi-year cycle that resets every three years. For this reason, it is very important that the savings you will be required to generate are based upon costs you can control.

Action Step: Visit the Chiropractic Summit's website and view "The Road to Implementation: Accountable Care Organizations" video in the Personal and Professional Development section.

Direct Pay

Under the direct-pay model of reimbursement, patients pay providers a flat monthly fee that grants them access to the health care services you provide. Also referred to as concierge care, this membership-like model also grants access to special services such as longer visits, house calls, preferred appointment times, and direct telephone, e-mail and even video chat access.

Direct-pay practices typically do not accept any insurance payments, resulting in a decrease in the overhead expenses associated with third-party payment. Monthly payments are usually automatically billed, creating an improved, predictable cash flow.

The direct-pay model changes the doctor-patient relationship, making doctors directly accountable to their patients. This allows you to focus on providing comprehensive, holistic care, rather than generating enough visits to pay your overhead.

If you are contemplating adopting a direct-pay model and are concerned that you may become overrun by your patients' demands, you can rest assured that this is typically not the case. Chiropractors who have converted to a direct-pay model report that most patients are respectful of their time. They also enjoy the predictable, steady income that allows them to focus on their patients, free from billing concerns.

In order for direct pay to be successful, you must limit the number of patients seen in your practice. The typical direct-pay practice caps the number of patients at about 800 per provider. Direct-pay patients are advised to have some form of catastrophic insurance coverage.

Action Step: Read Donald Petersen Jr.'s recent article, "Redefining the Doctor-Patient Relationship," to learn more about the concierge model and how a Kansas-based practice is implementing it.

Capitation

Capitation is a reimbursement model that pays providers a set amount for each enrolled patient assigned to them for a set period of time, whether or not that patient seeks care. Providers are generally contracted through a health maintenance organization or independent practice association that enlists the providers to care for the enrolled patients.

The rate of remuneration is based upon the average expected utilization of patients, with greater payment for patients with a significant past medical history. Rates are also based on age, sex, race, geographic location and type of employment, as these factors can also influence the cost of providing care.

When combined with quality metrics and insurance risk management, capitation can work. Providers (such as chiropractors) who work under these plans and focus on preventive health care have the potential for greater financial reward than those who are focused on the treatment of illness and disease. This is because capitated plans reward providers for averting the use of expensive diagnostic testing and treatment options. Capitation can only work when both payers and providers are on the same team, with a focus on providing quality care.

Action Step: Visit the American Chiropractic Association's website and check the Chiropractic Networks Action Center for information about any managed care organization you are considering

joining.

Fee-for-Service

While most experts agree that gradually more reimbursement will be value-based and not volume-based, the likelihood is that fee-for-service will remain part of the health care system for a long time to come. Under the Affordable Care Act, more patients have insurance coverage with high deductibles and limited economic means. For this reason, it is more important than ever for chiropractors to implement efficient ways to calculate patient financial responsibility and be proactive about it.

When patients with a high-deductible insurance plan phone your practice to make an appointment, the first thing your staff should do is to help them understand your payment expectations and their options. Your practice must be prepared to outline a monthly payment strategy to patients, compliant with state and federal laws, before services are rendered. Everyone on your practice staff should know the costs involved with care and chiropractors must be able to explain why services are necessary.

The discussion of patient finances does not need to be a difficult one. Calculating payments in advance and providing your patients with a detailed, line-itemed list of the services and procedures you will provide places the responsibility for payment in the patient's hands early in the process. This allows them to make payment arrangements so they can receive the care they need.

Action Step: Visit the website for the National Association of Insurance Commissioners for the contact information of your state's insurance commissioner. Ask for a list of the discount medical plan organizations (DMPOs) for chiropractors operating in your state. Joining a DMPO can protect your practice from illegally discounting your fees.

Navigating the new reimbursement models requires a level of business savvy that will demand effort on the part of most health care providers. However, the qualities of compassion and caring that come naturally to chiropractors means our focus will always be on the quality of care our patients receive. This places our profession in the sweet spot of the new value-based reimbursement paradigm.

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