

Managed Care Contracts:

Key Review Strategies for Revenue Enhancement

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Agenda

- The Affordable Care Act's impact on local managed care
- Terminology: Understand how you are getting paid
- Contract Provisions: Complete documentation
- Contract Definitions and Processes: Understand how to avoid denials and re-work
- PPO Networks: Know exactly who is paying you
- Ownership of patient data
- Eleven current payor initiatives
- Managed care contract compliance strategies
- Managed care contract language currently in play



The Patient Protection and Affordable Care Act

- The Patient Protection and Affordable Care Act (PPACA/ACA) has removed major financial controls on health coverage, forcing payors to offer high deductible or high premium coverage.
- Understanding reimbursement methodology and corresponding contract language is crucial in realizing all of your eligible revenue from commercial payors.



ACA & Managed Care

- No coverage limitations, e.g., denials, on pre-existing conditions
- No lifetime limitations on benefits, e.g., substance abuse programs
- External appeal process on denied tests or treatments
- Cost-free preventive services: no deductible or co-insurance
- Use of nearest ED with no penalty, no prior authorization, and no out-of-network benefits
- Coverage for dependent children until age 26



Managed Care Terminology

- Indemnity, Fee for Service
 - Original method of reimbursement for health insurance coverage
 - Premiums determined by actuaries
 - All covered claims are paid at 100%
 - Premiums reflect charges of providers
 - More services equate to more payment
 - No incentives to control cost



Managed Care Terminology

- Per Diem
 - “Per Day” equating to a fixed amount per patient per inpatient day
 - Common in most network arrangements
 - Initiated in the early 80’s to control costs
 - Incentives for hospital to manage costs
- Capitation
 - “Per Head”
 - Prepaid amount per enrolled member per month regardless of utilization
 - Incentives designed to keep the patient healthy



Managed Care Terminology

- Global Case Rates
 - Fixed payment for an inpatient stay or an outpatient procedure
 - Initially used by Medicare for DRG reimbursement
 - Common in PPO contracts for inpatient stays, cardiac cath, and deliveries
 - No incentive to reduce admissions or procedures
 - Incentives to reduce length of stay and cost per admission or procedure

Managed Care Terminology

- Utilization Review, Case Management
 - Patient Care “Management”
 - Usually performed by nurses controlling care throughout the course of treatment
 - Strives for quality care, but only as much as needed
 - Predecessor to Clinical Pathways and Treatment Protocols

Managed Care Terminology

- Clinical Pathways
 - Developed to standardize efficient treatment regimens
- Outcomes Research and Measurement
 - Emphasizes mortality and morbidity rates
 - Used by patients and payors to grade hospitals and physicians
 - Example: Infection rates for surgeries



Initial Managed Care Contract Analysis

- Who are the payor's major accounts/employer groups?
- Are the payment provisions compliant with Ohio State requirements?
- Do addendums to contracts include Medicaid plans for other states?
- Payor overpayments:
 - Recoupment policy
 - Recoupment timeframes



Contract Provision Basics

- Use definitive language
 - This provider Agreement (“Agreement”) is entered into by and between XYZ Payor (“Company”) and 123 Hospital, an Indiana nonprofit corporation (“Hospital”) and is effective the _____ day of June, 2014.
 - Define “Hospital” and “Company”
 - Always complete the effective date: no blanks!



Contract Provision Basics

- Request copies of all documents incorporated by reference
 - Provider Manuals
 - Utilization and Authorization Procedural Guidelines
- Attach documents incorporated by reference as an Exhibit
- Require 30 days written notice of any changes to contract documentation impacting the organization financially, and a corresponding redline copy of proposed changes
- Refuse e-mail notices; require paper
 - **Language:** Any document incorporated by reference in this Agreement must be provided to Hospital prior to the execution of the Agreement. The Hospital will be notified 30 days in advance prior to any changes made to documents incorporated by reference.



Contract Definitions: Medical Necessity

- “Medically Necessary” or “Medical Necessity” means services or supplies received from the provider **that Plan determines are medically appropriate...**
 - Site criteria, e.g., Interqual, Milliman
 - Who at the plan is applying the criteria?
 - How long does payor have to make a medical necessity determination?
 - Can the patient be billed?
- **Include in the contract definitions**



Contract Definitions: Medical Necessity

- **Medically Necessary** means health care services or supplies that are appropriate with regard to the general standards of medical practice and, as determined by the Medical Director, can reasonably be expected to (i) prevent or diagnose the onset of an illness, injury, condition, primary disability or secondary disability; (ii) cure, correct, reduce or ameliorate the physical, mental, cognitive or developmental effects of an illness, injury, or disability; or (iii) reduce or ameliorate the pain or suffering caused by an illness, injury, condition or disability. However, notwithstanding the above, the services or supplies must not be solely for the convenience of the Covered Person or his or her Provider; and must be the most efficient and least restrictive level of services or supplies that can be safely and effectively provided to the covered person.



Contract Definitions: Non-Covered Services

- A clear definition of “Non-Covered Services” needs to be included in the contract
 - **“Non-Covered Services”** means health care services that are not Covered Services, as defined in this Agreement.
- Billing members for non-covered services requires an advance notification (e.g., ABN)
 - Make sure this language is included in the contract



Contract Definitions: Non-Covered Services

- Co-payments and deductibles
 - Waiving these charges could be a violation of state and/or federal law
- Guaranty of Services
 - Do not guarantee to provide services
 - Instead, “Make available on the same basis for all other patients of the Provider”
 - Adding this language will prevent the Hospital from paying for a patient from going to a different hospital to receive care if the ICU is full and the ED is on divert



Contract Definitions: Emergency

- **“Emergency”** means a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of the individual (or unborn child); (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. **“Emergency Services”** means those services necessary to screen for, diagnose or stabilize and Emergency medical condition.

Contract Definitions: Emergency

- Add language stating that if a Covered Person presents to the ED, a “screening exam” under EMTALA **will be paid for** even if it is later determined that patient did not have an actual emergency.
- The Agreement should differentiate between emergent and urgent care.



Contract Definitions: Termination

- The effective date of this Agreement is the date set forth above, unless earlier terminated by either party as set forth below. The parties agree that the financial provisions of this Agreement set forth in Exhibit A shall be in effect for the period _____ through _____. The parties agree that annually, no later than sixty (60) days prior to the end of each year of the Agreement they will meet and agree on the financial terms set forth in Exhibit A. Should the parties fail to agree on revised financial terms then the rates set forth in Exhibit A shall automatically increase by _____%.



Contract Definitions: Termination

- This language provides for automatic renewal and annual rate negotiations.
- Specific termination provisions
 - How long will the Hospital be obligated to provide services after termination?
 - How much advanced notice is required?



Contract Definitions: Termination

- Either party may terminate this agreement at any time without cause by giving the other party at least ____ () days advance written notice.
- **AVOID**
 - “Hospital shall notify Cover Persons after the Date of Termination that it is no longer participating as a provider of Company.”
 - Notification of Covered Persons should be the responsibility of the payor
 - Compromise: Notify all Covered Persons in house of termination



Process: Eligibility Verification

- Telephonic Eligibility Verification. Company shall maintain a toll-free, twenty four hour seven day per week service to verify the eligibility of the Covered Person. (xxx-xxx-xxxx). Each time the Provider verifies eligibility for a Covered Person, the Provider will be given a unique number which shall serve as the Provider's documentation that it has confirmed the eligibility of the Covered Person.
 - Attain a unique number for both eligibility and pre-authorization from the payor
 - If eligibility is performed electronically, take a screenshot and include in the patient record



Eligibility Verification: Dual Coverage

- Patients will provide insurance information for the plan they think has the best benefit
 - Correct insurance may be provided after services are performed and charges are billed
- Correct Insurance Information. Should the Covered Person fail to give Provider the correct insurance information at the time of admission, Provider's claim shall not be otherwise denied if at the time of admission the Covered Person was a covered person under the Plan.
 - Claims cannot be denied for pre-authorization or PFL once the correct payor is determined and billed



Process: Authorization/Referral

- Clearly define procedures for obtaining an authorization
 - If the surgeon, not employed by the hospital, obtains an authorization for a procedure, verify if that authorization applies to the hospital stay
 - A procedure authorized by the primary plan may not be honored by a secondary plan, unless it is in the contract language
 - An authorized procedure can be later denied for medical necessity unless specific language is included in the contract
 - If a procedure has been prior authorized, charges for these services cannot be denied

Process: Dispute Resolution

- What is the Hospital's policy?
 - Arbitration
 - Use caution with arbitration when money is owed on claims: arbitration administration has associated fees
 - Is arbitration binding or non-binding?
 - Is arbitration subject to any confidentiality provisions?
 - Jury Trials
 - Jury trials can be waived by contract language
 - Class Action Lawsuits
 - Payors are now including language that will include participating providers in class action lawsuits



PPO Networks

- “**Network**” is a provider network accessed by insurance companies and other claims payors; Network is not an insurance company or payor and is not liable for payment to the Hospital.
- Network requires payors with whom they have network rental agreements to apply contracted rates contained in this agreement for Hospital claims.
- Network provides access to the Hospital’s rates to applicable payors with whom they have network rental agreements.



PPO Networks

- Financial Solvency. Network shall, at all times maintain sufficient capital to pay claims of HOSPITAL. Network shall cause each Plan whose members utilize HOSPITAL pursuant to this Agreement to maintain financial solvency including obtaining adequate reinsurance. In the event such Plan fails to maintain solvency or adequate reinsurance, Network shall be liable for all claims which remain unpaid by Plan. In order to ensure compliance with this section, Network shall provide to HOSPITAL a performance bond in the amount of one year's projected claims of HOSPITAL for Covered Individuals seeking care from HOSPITAL pursuant to this Agreement.



PPO Networks

- No Network Rental. Network covenants, agrees and understands that it is prohibited from renting the Network to Payors on a one time basis in order to obtain a discount from HOSPITAL for patients receiving treatment at HOSPITAL who are not with a Plan or Payor listed in Exhibit ____.



Data Access: Caution

- Restrictions on use of data or information and over-reaching confidentiality clauses
 - Look for language restricting the Provider's ability to transfer patient information to other providers and/or subsequent insurers



Data Access: Caution

- Inspection of Records and Data Access. Provider agrees that Company shall have access to all data and information obtained, created, or collected by Provider related to Members (“Information”). Such Information shall be jointly owned by Provider and Company, and Provider shall not enter into any contract or arrangement whereby Company does not have unlimited free and equal access to the Information in electronic or other form or would be required to pay any access, transaction or other fee to obtain such Information in electronic, written or other form. Information shall not be directly or indirectly provided by the Provider to any competitor of Company. Any and all information and data provided to Provider by Company or at Company’s direction shall remain the sole and exclusive property of Company and shall not be disclosed by Provider to any third party.



Data Access: Revised

- Inspection of Records and Data Access. Provider agrees that Company shall have access to medical records and claim data, including itemized statement of charges, related to Members (“Information”). Provider shall not enter into any contract or arrangement whereby Company does not have unlimited free and equal access to the Information and electronic or other form or would be required to pay any access, transaction or other fee to obtain such information in electronic, written or other form. Any and all Information and data provided to either party by the other, when marked “Confidential” shall remain the sole and exclusive property of the person providing the Information and data and shall not be disclosed by the other party to any third party, without prior written consent of the party providing the Information or data.



Eleven Major Payor Initiatives

1. Targeted case management across the Continuum of Care
2. Protocols and guidelines across the Continuum of Care
3. Disease Management Programs
4. Physician profiling data for incented Primary Care Providers (based on quality and cost)
5. Physician Profiling Data for Specialists
6. Physician to Physician counseling of outlier doctors
7. Active Medical Director role in authorizing referrals and guiding to specific providers
8. Dedicated inpatient physicians/nursing follow-up
9. Telephone triage and advice lines
10. More precisely targeted prevention and screening
11. Next generation management information systems

Compliance Strategies

- Communicate agreement terms to all impacted departments in focused summary sheets
 - Medical Records: confidentiality, chart review, chart copying, and specific coding provisions
 - Patient Financial Services: billing, COB, timely filing, clean claims, reimbursement terms, appeals procedures
 - Finance/Accounting: reimbursement terms
 - Specialty Departments: Any department where services are carved out
 - Case Management: utilization review, prior authorization requirements



Compliance Strategies

- Additional considerations for Finance/Accounting/PFS:
 - Are claims paid in a timely manner and at the appropriate contracted rate?
 - How is evidence captured that electronically transmitted claims were received?
 - What plans continually request multiple copies of medical records and/or itemized statements?
 - Are system notes accurate when documenting communications with payors on claim status?
 - Are confirmations of faxes to payors kept?
 - Do you meet regularly with your payor representative to address payment and compliance issues?



Example Contract Terms

- Any claim adjustments, e.g., requests for reconsideration to denied claims, must be submitted within 90 days of receipt of the original claim.
- Payor will offset claims believed to be paid incorrectly by offsetting future payments to the Hospital.
- The Hospital may not bill the patient for services that are determined to not be Medically Necessary by Payor.



Example Contract Terms

- Payor can deduct payment for services they determine are not executed in a timely manner by the Hospital.
- Payor may recoup payment up to two years following the date of payment for services where prior approval or prior notification was not attained by the Hospital.
- Payor can withhold reimbursement or terminate this agreement (with 30 days notice) if the Hospital fails to submit chargemaster information or rate increase notifications.



Example Contract Terms

- The Hospital is responsible for notifying medical staff that they are required to admit and/or refer Payor patients to Payor Network Providers.
- Hospital must make an effort to inform Payor patients they will be subject to lesser benefits should they receive services from a non-Payor provider.
- The Hospital is required to verify pre-authorization for all non-emergent admissions and surgeries with the Member's physician.
- The Hospital is required to submit all transactions electronically to Payor within 60 days notice.
- Payor will determine and notify the Hospital when inpatient care is no longer required.



Example Contract Terms

- The Hospital can bill members for non-covered services as long as the Hospital has provided advanced notice/consent to do so.
- The Hospital may bill the patient for non-covered services as long as they attain signed consent from the patient on a standard form used with all other commercial payors.
- The Hospital is only allowed to collect a deposit from the patient on charges that will apply to the patient's unmet deductible.
- The Hospital may not bill the patient for any additional charges if they determine the patient responsibility with Payor's real time claim adjudication option and collect monies owed at the time of service.
- The Hospital may not waive the patient's financial responsibility, e.g., deductibles, co-payments, or coinsurance, without Payor's consent.



Ohio Prompt Payment

- Prompt Payment of Claims (Source: SB4 Ohio Revised Code (ORC) § 3901.381)
 - ...when a third-party payer receives from a provider or beneficiary a claim on the standard claim form..., the third-party payer shall pay or deny the claim not later than thirty days after receipt of the claim.

Questions?



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