AGENDA

I. Managed Care Cycle and Revenue Cycle Relationship
II. Contract Problem Trends
III. Case Studies – What are Others Doing?
IV. Contract Audit and Revenue Recovery
V. Key Contract Terms Affecting the Bottom Line
VI. Questions, Answers and Discussion
I. MANAGED CARE CYCLE AND REVENUE CYCLE RELATIONSHIP
I. MANAGED CARE CYCLE AND REVENUE CYCLE RELATIONSHIP

Revenue Cycle

- Charge Capture
- Order Entry
- Follow-Up
- Payment Posting
- Claims Processing

Contracts

- Negotiation
- Forecasting
- Strategic Response
- Monitoring
## I. MANAGED CARE CYCLE AND REVENUE CYCLE RELATIONSHIP (continued)

### Comparing the Cycles

<table>
<thead>
<tr>
<th>WHAT?</th>
<th>Managed Care Cycle</th>
<th>Revenue Cycle</th>
</tr>
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<tbody>
<tr>
<td>HOW?</td>
<td>Creative</td>
<td>Routine</td>
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<td>FOCUS</td>
<td>Strategic</td>
<td>Accounting/Operations</td>
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<td>PROBLEMS ADDRESSED</td>
<td>Get Paid</td>
<td>Get Paid</td>
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<td></td>
<td>How Much?</td>
<td>Right Amount (Simple)</td>
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<tr>
<td></td>
<td>Right Amount (Complex)</td>
<td></td>
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<tr>
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<td>Bilateral Negotiations</td>
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<td>STAFF SKILLS REQUIRED</td>
<td>Advanced Computer Analysis</td>
<td>Routine Computer Skills</td>
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<td>Customer Service Skills</td>
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<td>Professional Presentation</td>
<td>Staff Supervisory</td>
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<td>Continuous Process-Oriented</td>
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<td>Project-Oriented</td>
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<td>MANAGEMENT REQUIREMENTS</td>
<td>Delegated Authority</td>
<td>Staff Process</td>
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<td></td>
<td>Motivation Of Creative Function</td>
<td>Human Resources Issues</td>
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<td>IS Training</td>
</tr>
</tbody>
</table>
I. MANAGED CARE CYCLE AND REVENUE CYCLE RELATIONSHIP (continued)

Impact of Managed Care Contracts

- Mission
- Physician Relations
- Revenues
- Marketing
- Operations
- Patient Relations
- Market Share
- Competitiveness
I. MANAGED CARE CYCLE AND REVENUE CYCLE RELATIONSHIP (continued)

Managed Care Cycle

- Define Contracting Policies/Evaluation Criteria
  - Analyze and Forecast
  - Negotiate the Contract
  - Monitor and Report Performance
  - Evaluate
  - Guidance
  - Parameters
  - Fulfill
II. CONTRACT PROBLEM TRENDS
II. CONTRACT PROBLEM TRENDS

Payor Pitfalls

- Denying clean claims.
- Paying claims late.
- Paying claims inaccurately (underpayments).
- Downcoding/bundling/unbundling claims.
- Changing fee schedules.
- Failing to apply cost-of-living increases.
- Failing to pay according to special payment arrangements.
II. CONTRACT PROBLEM TRENDS (continued)

Provider Pitfalls

- Lack of managed care policies, infrastructure, and strategic direction.
- Inability to identify underpayments.
- Claims denial from operational problems.
- Inadequate patient information and documentation (eligibility and authorization denials).
- Inconsistent charge capture.
- Poor coinsurance/co-payment collection.
III. CASE STUDIES: WHAT ARE OTHERS DOING?
III. CASE STUDIES: WHAT ARE OTHERS DOING?

Success Formula

1. Know what you want. Set your goals and objectives.
2. Take actions to move towards your goals.
3. Monitor your results to see if you are closer to your goals.
4. Use others as role models to short-circuit your success.
III. CASE STUDIES: WHAT ARE OTHERS DOING?

Focus on Denials

- Denials Committee: Children’s National Medical Center, Washington, D.C.
  - Chaired by CEO.
  - Denials are “everyone’s job.”
  - Key component to $34 million business operations turnaround.
III. CASE STUDIES: WHAT ARE OTHERS DOING? (continued)

Focus on Underpayments

- Contract Audit Group: Community Hospital, Colorado.
  - Four FTE analysts.
  - Focus on contract analysis and audit.
    - Contract database.
    - Contract implementation.
    - Underpayment audit and recovery.
  - Recovery experience in excess of $3 million per year.
III. CASE STUDIES: WHAT ARE OTHERS DOING? (continued)

Focus on Communications

- CareAlliance Health Services: Charleston, S.C.
  - Contract management.
  - Databases – contract management software feeds into manual analysis and troubleshooting.
  - Dedicated payment audit analysts.
  - Payment resolution system crosses department lines.
  - Report cards.
    - Internal and external use of dashboard information.
    - Communicate performance on provider’s criteria regularly.
  - Recovery experience $4.4 million in 21 months.
III. CASE STUDIES: WHAT ARE OTHERS DOING? (continued)

- Contract improvement effort: multihospital system, Virginia.
  » Employed/affiliated practices.
    - Individual contracts consolidated into group contract.
    - Operational improvements from process.
  » Medical staff practices.
    - Training for practice administrators on improving contract operations.
III. CASE STUDIES: WHAT ARE OTHERS DOING? (continued)

Focus on Implementation

- Contract implementation plan.
  - Training on unique terms.
    - Registration.
    - Clinical/coders.
    - Business office.
  - Timely upload of contract parameters/fees.
  - Monitoring/audit of performance.
    - Use of managed care dashboard to report managed care loss ratio.
IV. CONTRACT AUDIT AND REVENUE RECOVERY
IV. CONTRACT AUDIT AND REVENUE RECOVERY

Two Sides of the Same Coin

Payor Pitfalls

Provider Pitfalls
IV. CONTRACT AUDIT AND REVENUE RECOVERY (continued)

Key Warning Signs

- Increases in commercial payor contractual adjustments.
- Significant denial increases.
- Overall denial rates of greater than 3%.
- Drastic changes in days in accounts receivable (A/R) or outliers.
- Health plan mergers or claims system changes.
- Specific recurring problems with individual contracts.
IV. CONTRACT AUDIT AND REVENUE RECOVERY

(continued)

Key Components of the Contract Audit Function

- Develop standards for analyzing payments.
- Regularly report the audit results to senior management.
- Design an interdisciplinary team for payment resolution.
- Train dedicated staff for forensic audit duties.
- Communicate results of audit directly to the CFO.
- Regularly communicate with health plans to discuss payment problems and issues.
- Measure the results on an ongoing basis.
IV. CONTRACT AUDIT AND REVENUE RECOVERY

"Reinventing" the Managed Care Function

- Internal infrastructure, policies and processes to:
  - Provide strategic guidance.
  - Monitor contract performance.
  - Analyze contract operations.
  - Recover contract underpayments.
  - Resolve problems (external/internal).
IV. CONTRACT AUDIT AND REVENUE RECOVERY
(continued)

Managed Care Infrastructure

- CFO/Controller
  - Oversight & Strategy

- Finance
  - Financial Data/Modeling Support

Patient Financial Services
- Billing & Collections
- Routine Follow-up

Managed Care
- Negotiation and Analysis
- Third-Party Payor Audit
- Relationship Management

Clinical Operations
- Quality Control
- Training
- Coding Compliance
- UM/Case Management

Registration
- Patient Data Capture
- Patient Point-of-Service Collections

Information Systems
- Claims Data Support
- Troubleshooting

Information Exchange & Process Collaboration

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IV. CONTRACT AUDIT AND REVENUE RECOVERY

(continued)

Objectives of the Audit Function

- IDENTIFY and PROVE payor contract noncompliance.
- CALCULATE and PROVE underpayments.
- IDENTIFY and FIX internal contract operational problems.
- Get PAID what you NEGOTIATED.
IV. CONTRACT AUDIT AND REVENUE RECOVERY

(continued)

Audit Process Overview

- Payor-Specific Contract Audit
- Recover Funds Retroactively
- Renegotiate Bad Contracts
- Improve Internal Operations
- Preliminary Assessment
IV. CONTRACT AUDIT AND REVENUE RECOVERY

(continued)

Typical Audit Activities

- Review financial reports by payor (aged A/R, etc.).
  - Identify significant A/R trends.
  - Review denial reports by payor.
- Review contract language, focusing on “key” contract points.
  - Payment timeliness provisions.
  - Audit rights.
  - Clean claims definitions.
  - Payment amendment provisions.
  - Annual rate adjusters.
  - Termination and dispute resolution.
IV. CONTRACT AUDIT AND REVENUE RECOVERY
(continued)

Typical Audit Activities

- Interview operational staff.
- Identify internal operational problems.
  - Administrative burdens and inefficiencies.
  - Contract term inconsistencies across payors.
- Review relevant payor-provided data.
- Assess contract rates, identify outliers.
- Sample for payment and submission errors, identify trends.
- Document key findings, opportunities and next steps.
### IV. CONTRACT AUDIT AND REVENUE RECOVERY (continued)

Example: Payment Timeliness Sampling

<table>
<thead>
<tr>
<th>Service Date</th>
<th>Service Posting Date</th>
<th>Lag</th>
<th>Invoice Date</th>
<th>Lag</th>
<th>Invoice Paid Date</th>
<th>Payment Lag</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/22/2002</td>
<td>3/24/2002</td>
<td>2.00</td>
<td>3/24/2002</td>
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<td>6/21/2002</td>
<td>89.00</td>
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<tr>
<td>3/22/2002</td>
<td>3/24/2002</td>
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<td>3/24/2002</td>
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<td>5/16/2002</td>
<td>53.00</td>
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<td>3/24/2002</td>
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<td>3/25/2002</td>
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<td>3/25/2002</td>
<td>0.00</td>
<td>5/19/2002</td>
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<tr>
<td></td>
<td></td>
<td>1.75</td>
<td>0.00</td>
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<td></td>
<td>58.88</td>
</tr>
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</table>
Example: Interest Calculation

<table>
<thead>
<tr>
<th>Payment Lag</th>
<th>Amount Paid</th>
<th>Interest Rate</th>
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<tbody>
<tr>
<td>89.00</td>
<td>$1,550.00</td>
<td>9.5%</td>
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<tr>
<td>53.00</td>
<td>$750.00</td>
<td></td>
</tr>
<tr>
<td>69.00</td>
<td>$625.00</td>
<td></td>
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<tr>
<td>53.00</td>
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<tr>
<td>55.00</td>
<td>$78.00</td>
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<td>56.00</td>
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<td>48.00</td>
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<td>48.00</td>
<td>$34.00</td>
<td></td>
</tr>
<tr>
<td>58.88</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Timeliness Requirement = 30 Days

\[
\text{= If (payment lag>30, amount paid\times(payment lag-30)\times(9.5\%/365),0)}
\]

\[
\text{= $1,550.00\times(89-30)\times(9.5\%/365) = $23.80}
\]
### IV. CONTRACT AUDIT AND REVENUE RECOVERY (continued)

**Example: Interest Owed**

<table>
<thead>
<tr>
<th>Service Date</th>
<th>Service Posting Date</th>
<th>Lag</th>
<th>Invoice Date</th>
<th>Invoice Paid Date</th>
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<th>Interest Owed</th>
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<tbody>
<tr>
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<td>03/24/02</td>
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<td>06/21/02</td>
<td>89.00</td>
<td>$1,550.00</td>
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<td>03/25/02</td>
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<td>$0.51</td>
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<td>1.75</td>
<td>0.00</td>
<td>58.88</td>
<td>$36.20</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
IV. CONTRACT AUDIT AND REVENUE RECOVERY

(continued)

Managed Care Loss Ratio: The ratio of underpayments to total dollars expected under the contract.

\[
\text{Managed Care Loss Ratio} = \frac{\text{Total Unpaid Claims}^{1} \text{ And Underpayments}^{2}}{\text{Total Amount Due Under Contract}}
\]

Effective Rate: The actual rate paid under the contract, including the effect of denials, underpayments, unpaid patient responsible amounts, and downcodes.

\[
\text{Effective Payment Rate} = \frac{\text{Total Payments Collected}}{\text{Total Services Provided (at contract rates)}}
\]

1. Includes denied claims.
2. Includes unpaid co-payments, coinsurance, and deductibles from patient.
**IV. CONTRACT AUDIT AND REVENUE RECOVERY (continued)**

**Calculating Effective Rate**

(For January services, 90-day effective rate is computed in May.)

<table>
<thead>
<tr>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billed</td>
<td>880,000</td>
<td>120,000</td>
<td></td>
<td>1,000,000</td>
</tr>
<tr>
<td>Collections</td>
<td>100,000</td>
<td>400,000</td>
<td>300,000</td>
<td>140,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>At Contract Rates</th>
<th>Indexed to Medicare (Contract = 200% of Medicare)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services Billed for January</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Collections During February, March, April</td>
<td>940,000</td>
</tr>
<tr>
<td>Managed Care Loss</td>
<td>60,000</td>
</tr>
<tr>
<td>Effective Rate</td>
<td>94%</td>
</tr>
<tr>
<td>Managed Care Loss Ratio</td>
<td>6%</td>
</tr>
</tbody>
</table>
## IV. CONTRACT AUDIT AND REVENUE RECOVERY

*(continued)*

### Managed Care Contract Dashboard

<table>
<thead>
<tr>
<th>Contract</th>
<th>Type</th>
<th>Contract Rate&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Annual Net Revenue</th>
<th>Annual Increases</th>
<th>1-Month&lt;sup&gt;2&lt;/sup&gt; Effective Rate</th>
<th>3-Month&lt;sup&gt;3&lt;/sup&gt; Effective Rate</th>
<th>Contract to Date&lt;sup&gt;4&lt;/sup&gt; Effective Rate</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payor 1</td>
<td>Per Diems</td>
<td>75%</td>
<td>$10.1M</td>
<td>Annual @ CPI</td>
<td>68%</td>
<td>60%</td>
<td>62%</td>
<td>Negotiated to reduce denials. Positively affecting payment rates.</td>
</tr>
<tr>
<td>Payor 2</td>
<td>DRGs</td>
<td>70%</td>
<td>$7.2M</td>
<td>Annual @ CPI</td>
<td>58%</td>
<td>64%</td>
<td>66%</td>
<td>Recent issues with downcoding. Business Office is preparing audit of claims.</td>
</tr>
<tr>
<td>Payor 3</td>
<td>Discount off Charges</td>
<td>80%</td>
<td>$5.0M (Max + 3%)</td>
<td>Charges</td>
<td>76%</td>
<td>70%</td>
<td>74%</td>
<td>New system has been implemented. Earlier problems diminished.</td>
</tr>
</tbody>
</table>

<sup>1</sup> Contract Rates are indexed to charges for a standardized review of services. Charges = 100.

<sup>2</sup> One-Month Effective Rate lag is currently 90 days. For February 2003, data is from November 2002.

<sup>3</sup> Three-Month Effective Rate lag is currently 90 days. For February 2003, data is from September 2002 through November 2002.

<sup>4</sup> Contract to Date Effective Rate lag is currently 90 days. For February 2003, data is through November 2002.
Next step strategic initiatives.

» Recover underpayments.

» Renegotiate bad contracts.

» Improve internal contract operations.
Negotiate payback directly with payor.

Terminate for breach unless a payback settlement and terms going forward are reached within a specified time period.

Negotiate more favorable contract terms using payment errors as a negotiating leverage point.

Proceed with mediation and/or arbitration.

Involve your state’s department of insurance.

Consider other litigation options.
Audit may find that certain payors are in compliance with contract terms but:

» Terms are unlivable (i.e., allows arbitrary fee schedule changes).
» Rates are not market-competitive and/or are unacceptable.
» Operational logistics are unreasonable.

May have opportunity to simplify operations for both parties.
Be prepared: have the results of your audit and the recommendations and proposals of your team.

Understand your market position and power.

Understand the level of risk to the contract relationship that you are willing to endure.

Know your plans to fix internal problems.

Know your fallback position (e.g., litigation) if negotiations fail.

Meet with payors regularly once initial underpayment dispute is resolved.
IV. CONTRACT AUDIT AND REVENUE RECOVERY

(continued)

- Negotiations with payors.
- Mediation.
- Arbitration.
- Litigation.
- Legislation.
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE

Top Ten List of Key Contract Provisions

1. Claims Submission and Payment Requirements
2. Payment Structures (Carveouts – Payments for High-Cost Drugs and Implants, etc.)
3. Definitions
4. Incorporation of Other Documents – (Provider Manuals, Plan Policies and Procedures)
5. Contract Term Time Frames and Termination Rights
Top Ten List of Key Contract Provisions

6. Access to Data

7. Unilateral Changes

7. Retrospective Denial and/or Downcoding (e.g., ED, Observation Days)

9. Silent PPOs

10. Dispute Resolution
Establish reasonable time period for claims submission (example: 90 days after service or discharge).

Refer to state requirements – Plan should be obligated to pay "clean claims" within 30 days or pay interest at a specified amount (e.g., 1.5% per month).

Avoid “best efforts” versus hard deadline.
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

- Perform historical analysis and benchmarking to determine most preferred payment structure.
- Preferences vary greatly by hospital, health plan, and geographic region:
  - Certain hospitals moving to DRGs due to administrative ease.
  - Others moving back to percentage of charges due to market leverage and profitability opportunity.
  - Many hospitals use per diems as compromise.
Regardless of payment structure, carveouts can make or break financial performance of the contract.

- Typical per diem/case rate carveouts:
  - Implants.
  - Prosthetics.
  - High-cost drugs.
  - Case rate length of stay outliers.
  - Global versus technical only.
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

- Understand the financial impact of carveouts and specify the details.
  - What is included in the per diem/case rate?
- Model various LOS and cost scenarios.

**HIGH-COST DRUG EXAMPLE**

- AWP plus 10% for full course of treatment of high-cost oncology drug (full course is six vials).
- Two vials of drug A used, patient responds negatively.
- Four vials of drug B used to complete course of treatment.
- Was a full course of treatment provided?
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

- Understand the details:
  - Transplant example: What is and is not covered?
    - Professional charges.
    - Immunosuppressant drugs.
    - Organ procurement.
    - Readmissions.
  - Cardiac surgery example:
    - Will catheterizations be performed as inpatient procedures (adds 2–3 days)?
    - Flat per diem rates may not reflect service intensity.
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

Key Definitions

- “Clean Claim.”
  - “A properly completed billing form UB–92 or HCFA 1500 or a form containing equivalent information, including complete ICD–9 or CPT–4 coding.”
  - Incorporate a list of the required data fields for a “clean claim” as an attachment to the contract.

- “Payor.”
  - Define clearly (not just "Plan and Affiliates") so that the entity obligated to pay is identified and the provider has a right of action against that entity.
“Emergency services.”

- The Emergency Treatment and Active Labor Act (EMTALA) requires hospitals that provide emergency services to screen and stabilize all persons who present at the facility, without asking how they will pay for services.

- Avoid requirements to seek preauthorization for the provision of emergency services in violation of EMTALA.
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

- Definition of “day” in per diem contracts.
  - Avoid language defining a day as “in the 24-hour period before the midnight census.”
  - Some plans require that members be an admitted inpatient for the full 24-hour period.
  - Avoid language stating that “plan shall reimburse hospital at a per diem of $X.”
  - Clarify definition to state that “any member admitted at any time during the 24-hour period” will count for that day.
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

Incorporation of Other Documents

- Provider should not be bound by provisions of any document (such as plan policies and procedures) unless:
  » Provider has reviewed document.
  » Document is attached to the contract.
- Any material provisions should be included in the contract and not just incorporated by reference.
- Consider implications of future changes to documents incorporated by reference.
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

Incorporation of Other Documents

- Contract should state that:
  “Such manuals serve an administrative purpose in implementing the relationship between the parties and that it is not the mutual intent of the parties that any term of the manuals will contradict, modify, or otherwise affect the terms of the contract.”
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

- Provider should have the right to terminate without cause with reasonable notice.

- Consider termination notice period.
  - Shorter if concerned about payor solvency.
  - Longer if desire to lock in relationship.

- Right to terminate immediately (or the agreement should terminate automatically) in the event of bankruptcy, insolvency, etc.

- Right to terminate with cause on very short notice if claims are not paid on time.
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

- Right to terminate participation in specific product or payor is desirable.
- Avoid requirement to care for patients covered under the terminated contract at the same rates for up to a year after the contract terminates.
- Negotiate for higher rates for care of acutely ill members that continue after the contract is terminated.
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

- Get cross rights to access data, if the plan’s data affects your payments.
- Data should be provided in a specified format.
- Regular time frames for provision of data should be established.
Unilateral Changes

- Plan should not be able to unilaterally change the terms of the agreement; watch out for “red flags:”
  - “From time to time.”
  - “At the plan’s discretion.”

- Require consent of provider or prior notice of change to provider, depending on type of change.

- Notice should be provided to specified provider administrator (e.g., CFO, CEO) via certified mail.
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

Unilateral Changes

- Important for material provisions:
  - Rates.
  - Plan’s UR policies or procedures.
  - Appeals process.

- Avoid language allowing the payor to define a term of the contract unilaterally (e.g., acute care day).
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

- Negotiate specific rates or indexed rates.
  - Percentage of Medicare (physicians).
  - Percentage of charges.

- Do not accept the payor’s unknown schedule of fees (common for physicians).

- Negotiate terms of annual cost-of-living adjustments to rates by a predetermined public index.
  - Medicare Economic Index.
  - Premium changes as reported in the filings to the DOI.

Unilateral Changes:
Fee Schedule/Rate Changes
Plan should not be able to retrospectively deny payment for services already authorized through preauthorization or concurrent reviews.

Negotiate out language disclaimer that “any preauthorization or verification of coverage is not a guarantee of payment.”

The disclaimer is not automatically enforceable against providers.

Many states (43 and Washington, D.C.) have laws or court decisions restricting plans from retroactively denying payment for claims where coverage was verified or services were preauthorized.
Depending on the terms of the contract, silent PPO activity may constitute a breach.

AMA believes that silent PPO activity may be fraudulent.

It is estimated that providers nationwide have lost between $750 million and $3 billion annually since the practice began in the early 1990s.
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

Silent PPOs: What are They? An Example

- Hospital X negotiates a 30% discount with PPO X.
- Patient X who is covered by an indemnity plan visits Hospital X, which treats the patient.
- Hospital X bills the indemnity insurer charges.
- Indemnity insurer contacts a TPA, broker, or any PPO to determine whether Hospital X has agreed to a discount.
- PPO X offers to allow the indemnity insurer to use its 30% discount, for a fee.
- Indemnity insurer remits discounted payment w/an EOB.
- Hospital X is instructed to collect a co-payment/deductible from patient.
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

- Attach a complete payor list to the contract. Require plan to provide notice of changes to the list.
- Include specific language:
  - “Plan represents to provider that neither Plan nor any claims paying organization with which it is affiliated by ownership or contract, nor any payor (or agent of any payor) shall lease or sell the reimbursement rates established for the provider under this Agreement or reprice claims for services other than claims for the Covered Services defined in this Agreement.”
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

 Silent PPOs: What Can You Do?

- Require coverage differentials between in-network and out-of-network providers.
- Require inclusion of the PPO’s name on all member identification cards and require that cards be presented at the time of service.
- Require identification of payor’s use of PPO on the EOB.
- Audit claims payment practices.
- Be sure to make a copy of the patient’s ID card.
- Ensure that PPO name or ID number is listed on the card.
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

Silent PPOs: What Can You Do?

- Match payor name or ID number on the EOB with the payor name or ID number on the card.
- Know which employers are contracted with which payor/PPO.
- Identify duplicate payor/employers on PPO’s list.
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

- Bundling.
  Example: Including fetal stress tests or sonograms in the 59400 code for a routine delivery.

- Unbundling.
  Example: Requiring lab testing codes to be billed separately to reduce reimbursement.

- Downcoding.
  Example: Routinely paying endoscopies at the lowest code, even if provider performs biopsies.

- IMPACT: 1. Lower reimbursement.
  2. Increased risk for billing errors.
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

- Put protection in the contract language requiring plan to follow the CPT manual:
  - Be sure that the contract specifies the edition and year of the manual.

Code Bundling/Unbundling: What can you do?

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V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

Code Bundling/Unbundling: What can you do?

- If plan insists on using its own coding manual, obtain a copy and review for reasonableness.
  - If manual is acceptable, refer to it in the contract.
  - Include manual as an attachment to the contract.
  - Add additional language: “The Manual is attached hereto and incorporated by reference herein. The Manual shall not be changed by the Plan without the prior written approval of Provider.”
Many states prohibit insurers from engaging in any “unfair claim settlement practice.”

- Often includes failing, upon request, to give provider written information regarding the specific payment rate and terms.
- Prohibits insurers from denying payment of a claim for any reason that is not clearly described in the insured’s policy.
- Requires insurers to provide a written explanation of any part of a claim that is denied.
Code Bundling/Unbundling: What can you do?

- Request a written explanation of the coding rules and claim logic.
- Draft a letter referring to state bill (if it applies) if plan is seemingly committing an unfair claim settlement practice.
- File a complaint with the Department of Insurance.
- Renegotiate contract language to address coding issues specifically.
- Audit payment practices to identify contract breaches to use as negotiating leverage.
V. KEY CONTRACT TERMS AFFECTING THE BOTTOM LINE (continued)

Dispute Resolution

- Dispute resolution options:
  - Silent.
  - Nonbinding and binding mediation.
  - Nonbinding arbitration.
  - Binding arbitration.
  - Litigation.
QUESTIONS, ANSWERS, AND DISCUSSION

For more information, please contact:
Paul B. Stevenson
ECG Management Consultants, Inc.
1501 Lee Highway, Suite 303
Arlington, Virginia 22209
(703) 522-8450
pstevenson@ecgmc.com