HEALTHCARE

Payor Contracting

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PAYORS… DEFINED.

Answering the fundamental question of who or what is the "Payor" may be complex and definitions may vary. Simply, a Payor is an entity that pays for services rendered by a healthcare Provider. The Payor may be a commercial insurance company, government program, employer, or patient. Providers may also contract with third-party administrators (TPAs) or intermediary contracting entities, including other health care Providers who have assumed financial risk from a Payor. The identity of the Payor may determine the degree to which terms are fixed or negotiable, the applicable laws, negotiating strategy and goals and objectives of the relationship. Common examples of "Payors" include:

Health Maintenance Organization (HMO): HMOs contract with a network of health care Providers that have agreed to the HMO's reduced payment structure or fee schedule (FS). Care provided under an HMO is covered only if a Member engages Providers within the HMO's network.

Preferred Provider Organization (PPO): This is a type of health plan that contracts with medical Providers, such as hospitals and doctors, to create a network of "preferred" Providers who agree to the PPO's payment structure, or FS for services. PPOs may also offer coverage for services provided by nonpreferred (non-contracted) Providers.

Accountable Care Organization (ACO) or Clinically Integrated Network (CINs) – The voluntary networks of Providers are typically organized and managed by health care Providers instead of insurers with the goal of delivering high-quality, coordinated care. The ACO or CIN may contract with insurers on behalf of the Providers and may require the Provider to adhere to ACO or CIN clinical guidelines for care.

Exclusive Provider Organization (EPO): EPOs are similar to PPOs, however, EPOs typically require Members to receive services *only* from participating Providers.

Third Party Administrator (TPA): An entity that contracts with ERISA plans to administer the health plans, including claims adjudication and payment, utilization management, Provider contracting, and other administrative functions necessary for plan operations.

Fee-for-Service (FFS) Government Programs: Medicare, Medicaid, Workers' Compensation, Veterans' Administration, etc. The terms of such plans are typically set by the government entity with little to no room for a Provider or practice to negotiate different rates.

Point of Service (POS): A POS plan is a hybrid PPO/HMO which provides the flexibility of a PPO while retaining cost controls. For example, POS plans may offer coverage for services provided by non-preferred (non-contracted) Providers, but only upon a referral from a primary care Provider (PCP).

Employee Retirement Income Security Act (ERISA) Self-Funded Employee Benefit Plan/Union Trust: An employer-sponsored health benefit plan where financial responsibility for overall cost of care lies with the employer versus with an insurer. These plans are typically exempt from state laws.

Leased Network/Contracting Networks: Provider networks are typically organized and managed by entities other than insurers. The network contracts with Providers to form a network that insurers pay to access, including self-funded plans and their TPAs.

Health Care Sharing Ministries: A nonprofit ministry that solicits contributions for sharing of health care costs among Members. ***Note: Health Care Sharing Ministries are not "insurers" but are recognized under the Affordable Care Act as satisfying the requirement for individual coverage.***

Payor Contracting Sample Language

The Payor contract is an Agreement stipulating contractual terms between the Payor and the Provider. Therefore, it is important to identify terms that are particularly beneficial to both Parties. The provisions described here are frequently negotiated, and as reflected below, may be written in a manner that favors one party over another. ***The examples provided are intended for educational content only and may not be appropriate to use in specific Payor Agreements without further review or modification or without seeking legal advice.***

FLuidity Writing Services and FLuidity Healthcare Solutions do not guarantee the enforceability or appropriateness of this language when applied to any Agreement. Providers should seek guidance from experienced health care counsel in connection with any use of this sample language.

Eligibility

Favorable to Provider:

Payor shall be responsible for identifying and verifying eligibility of Members. Payor shall provide each Member with an identification card. It is the Payor's responsibility to update and maintain eligibility files and systems to ensure that eligibility verification is timely and accurate. Provider may rely on eligibility verifications obtained from a Payor or its designee and Payor shall reimburse Provider in accordance with this Agreement even if a Member is later determined to be ineligible on the date of service.

Favorable to Payor:

Provider will verify a Member's eligibility before providing a Covered Service unless the situation involves the provision of an Emergency Service in which case Provider will confirm eligibility in a manner that is consistent with Law on redeterminations of eligibility. Provider will not be reimbursed for any services furnished to a patient who was not an eligible Member on the date of service.

Overpayments and Recoupments

Favorable to Provider:

Notwithstanding any other provision of this Agreement, Payor shall issue requests for overpayments to Provider within ninety (90) days from the date of the initial Claim payment or it shall be waived by Payor except in instances of fraud or misrepresentation by Provider. In no event shall Payor offset overpayments against amounts due to Provider without Provider's written consent.

Favorable to Payor:

In the event of an overpayment, Payor will issue an overpayment letter requesting repayment of the funds. If the Provider does not timely dispute or repay the overpayment within sixty (60) days, Payor may collect the amount by offsetting or recouping from any amounts due to the Provider. Provider will promptly notify Payor and applicable governmental agencies of any overpayments identified by Provider. Notwithstanding any other provision of this Agreement, the offset and recoupment rights for an overpayment may be exercised to the time period permitted by Law.

Contract Amendments favorable to Provider:

Any Amendment to this Agreement shall require the mutual written agreement of both Parties.

Favorable to Payor:

Payor may amend this Agreement upon forty-five (45) days prior written notice to Provider. The proposed Amendment shall take effect unless Provider notifies Payor of its termination of the Agreement within forty-five (45) days of receipt of the notice of amendment.

Provider Manual / Payor policy changes <u>favorable to Provider:</u>
Provider shall comply with the Provider Manual and all applicable policies of Payor in effect as of the Effective Date of the Agreement and as provided to Provider. Payor shall notify Provider at least ninety (90) days in advance of implementing any new policies or making material changes to the Provider Manual. A "material change" shall include, but not be limited to, (i) any changes to or negative impact to reimbursement to Provider; and (ii) any increased operational or administrative burden to Provider. In the event Provider objects to a material change, the change will not take effect as to Provider without the mutual written agreement of the Parties.

<u>Favorable to Payor:</u>
Provider shall comply with the Provider Manual and all applicable policies of Payor, any of which may be amended by Payor from time to time at the Payor's sole discretion.

Special Considerations for Value-Based Agreements

Agreements with a value-based component create unique legal considerations. For example, an Agreement involving value-based payment may require the Provider to contract through a preferred network or submit additional data. It may also involve data sharing and payment terms associated with non-FFS models like shared savings. Also, it is important to understand the risk arrangement being discussed as this will impact payment.

1. **Language permitting downcoding**
   Certain Payor Agreements, policies, or manuals now contain language permitting the Payor to override a service billed by a Provider, and unilaterally reimburse the Provider for a different service at a lower rate. This may be true even if the Provider has fully documented the medical necessity of the service if the Payor is using technology or a vendor to determine what the Provider "should have" billed. Examples of recent contractual language allowing this practice are as follows:

   Example 1: *In an effort to reduce the administrative burden of requesting and submitting medical records for review, [Payor] will begin using [Proprietary Tool] which determines appropriate evaluation and management (E&M) professional coding levels based on data such as patient's age and conditions for the Medical Decision-Making key component. [Payor] will presume the Provider meets the requirements of the E&M code level they have submitted related to the history and exam key components for the initial adjudication of the claim.*

   Example 2: *[Payor] will review Emergency Services claims to determine appropriate use of emergency room and whether an emergency medical condition existed. At a minimum, both the facility and the Provider will receive reimbursement for screening services:*
   a) For Provider services billed on a CMS-1500 claim: If a prudent layperson review determines that the service was not an emergency, [Payor] is required to reimburse, at a minimum, for Current Procedural Terminology (CPT) code 99281, the Emergency Department Visit Level 1 screening fee.
   b) For facility charges billed on a UB-04: If a prudent layperson review determines the service was not an emergency, [Payor] must reimburse for revenue code 451, EMTALA Emergency Medical Screening Services.

2. **Language permitting or requiring bundling of distinct services**
   Some Payors are adopting software solutions or using third-party vendors to group Provider services into bundled services. This is often based on the Payor's determination that reimbursement for distinct services is already reflected in payment for a single comprehensive code. In some cases, this means the Payor may avoid separate payment for services performed and properly documented by a Provider, based on software edits grouping the service into a bundled code. Providers should understand how Payors will apply these "bundling" policies and their rights to appeal or contest the decision to bundle services this way.

Example: *Effective [Date], we will begin using [Software], a new clinical code editing software for medical and behavioral products. [Software] will facilitate accurate claim processing for medical and behavioral claims submitted on a CMS-1500 claim form. [Software] code auditing is based on assumptions regarding the most common clinical scenarios for services performed by a health care professional for the same patient. [Software] logic is based upon a thorough review by Providers of current clinical practices, specialty society guidance, and industry standard coding. Services considered incidental or mutually exclusive to the primary service rendered, or as part of a global allowance, are not eligible for separate reimbursement. Patients covered under [Payor]administered plans should not be balanced billed for clinically edited non-paid services. A procedure that is performed at the same time as a more complex primary procedure, requiring little additional Provider resources and/or is clinically integral to the performance of the primary procedure, is considered incidental to the related primary procedure(s) on the same date of service and will not be separately reimbursed.*

3. **Language on payment options**

   Some Payors are adopting electronic payment requirements through third parties that may impose additional costs on the Provider. Providers should understand all reimbursement options from the Payor and any costs associated with each reimbursement option.

   Example: *[Third party vendor] offers the following payment options:*

   a) *Electronic Funds Transfer (EFT) – EFT is a fast and reliable method to receive payments and is the preferred method for [Payor]. In order to register for [Payor] payments and choose EFT as your payment preference, visit [Third party vendor] registration page.*
   b) *Virtual Card Payment – Standard credit card processing and transaction fees apply. Fees are based on your credit card processor's fees and your current banking rates. [Third party vendor] does not charge any additional fee for processing. For each payment transaction, a credit card number unique to that payment transaction is sent either by secure fax, or by mail. Processing these payments is similar to accepting and entering patient payments via credit card into your payment system.*
   c) *Paper Check – If your office would prefer to receive check payments, please call [Third party support] at [customer support number].*

4. **Language for required use of specialty pharmacies**

   An increased number of Payors are contracted with a third-party specialty pharmacy to lower up-front medication acquisition costs to Providers, integrate coordination of coverage between Provider, patient, and Payor, assure compliance with guidelines and standards, and others. Providers should understand options for specialty pharmacies for each Payor, required use of specialty pharmacies. It is important to note that some Payors may have different requirements for each plan. Providers should check specific plan requirements prior to medication administration.

   Example: *[Payor] contracts with select specialty pharmacies to obtain specialty medications for Provider administration to our Members. Specialty medication coverage is based on the Member's benefit. Prior Authorization or predetermination approval may still apply to specific specialty medications. In accordance with their benefits, some Members may be required to use a specific preferred specialty pharmacy, or be subject to a split fill program, for benefits to apply. For more information about medical criteria, please refer to the Medical Policies.*