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Contracting & Credentialing

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DISCLAIMER

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Meet Your Presenter

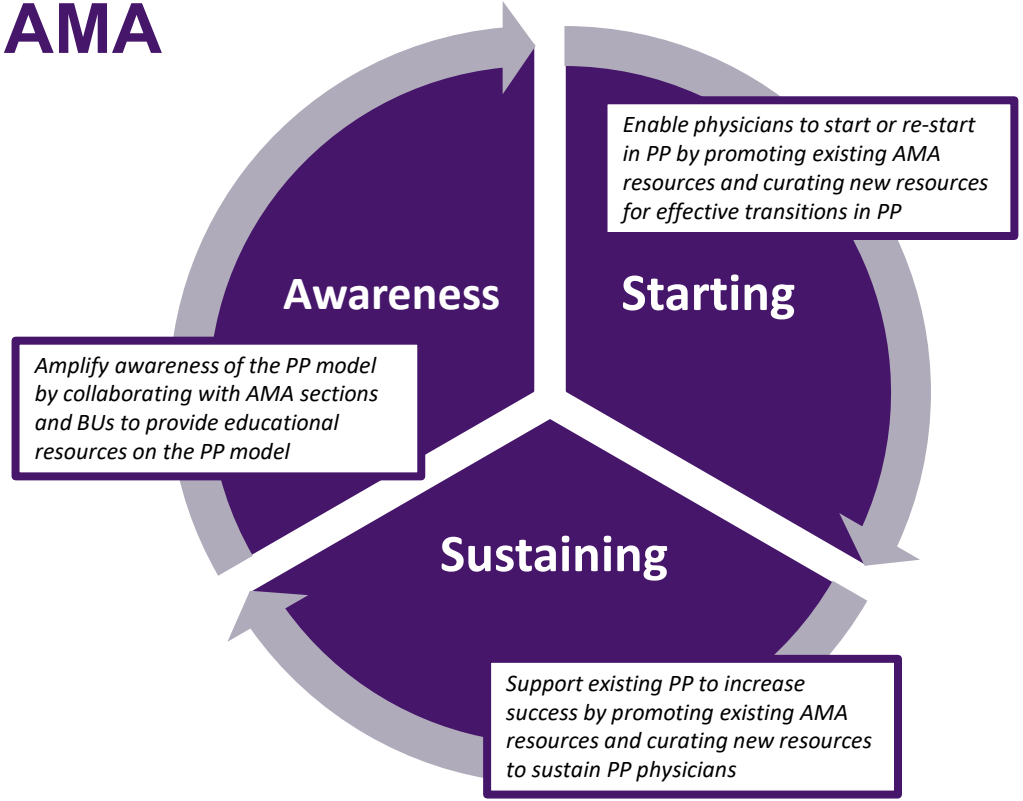
- Manager, Physician Practice Development, American Medical Association
- Education
  - B.S. Health Systems Management, Loyola University Chicago
  - MBA, Entrepreneurship, Pepperdine University.
- 10+ years of health care administrative experience in private practice, including managing business and clinical operations, as well as consulting knowledge for large-scale health systems.

Taylor Johnson, MBA, CMPE

Private Practice at the AMA

Objective: Physicians have the exposure, tools, and information needed to choose the practice setting that is right for them and leads to their professional satisfaction and long-term practice sustainability.

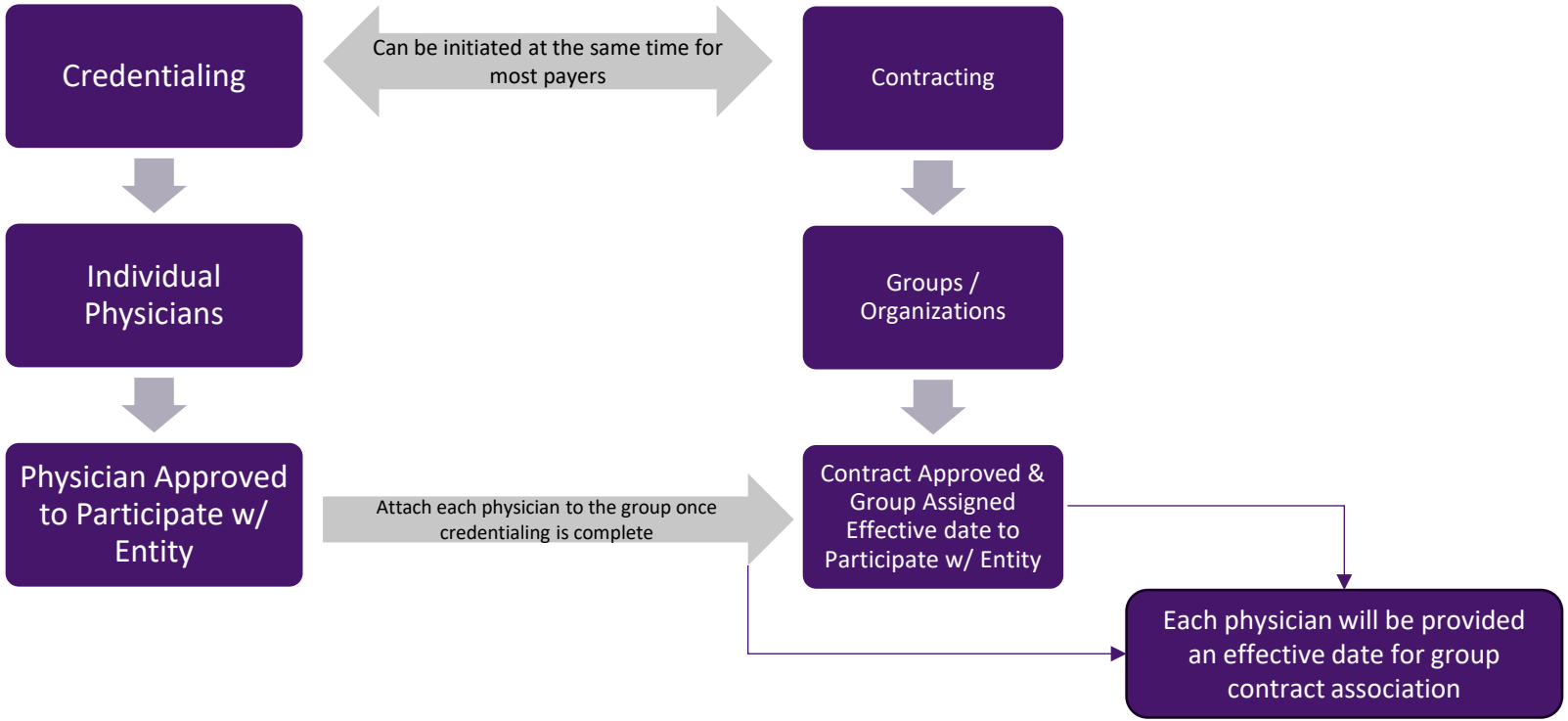
Scan for private practice tools & resources!



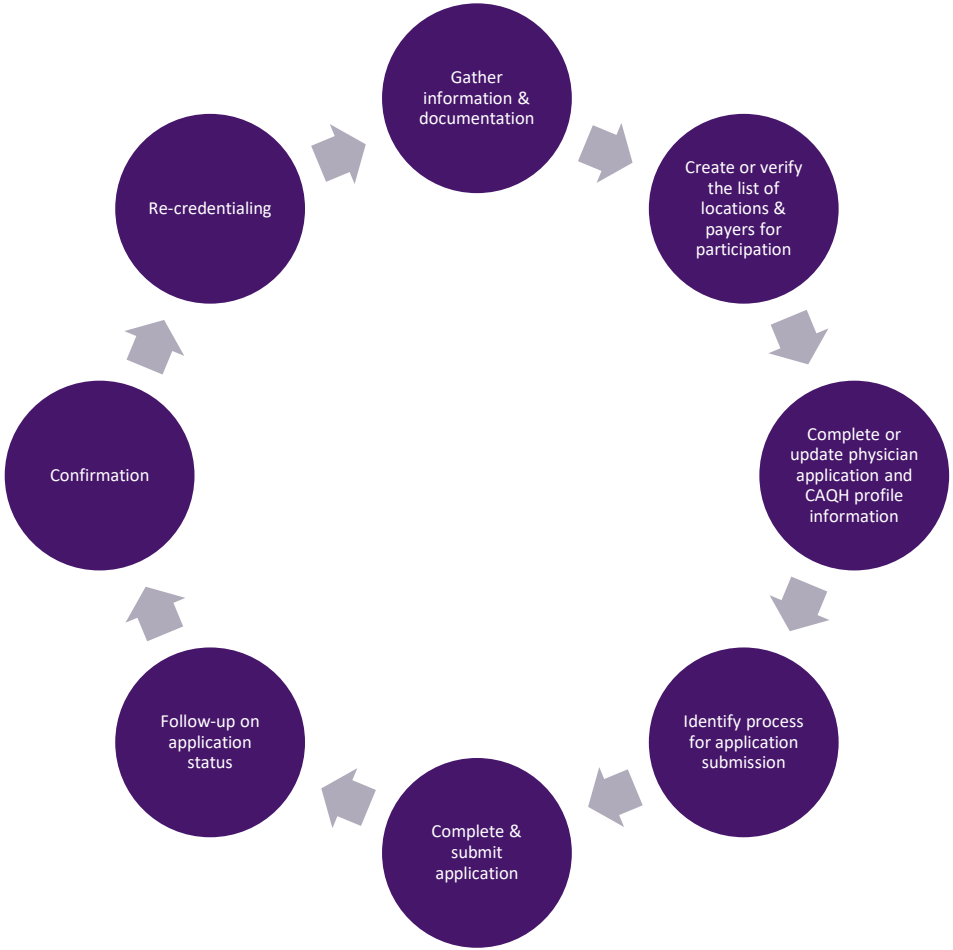
Agenda

- Physician Credentialing & Contracting
  - 8 STEPS to Credentialing and Contracting
  - Common roadblocks
- Basics of Contracting
  - Payer Types, Products & Reimbursement Models
  - Important Contract Terms
  - Contracting Trends
  - Common Value-Based Care Approaches

Overview of Physician Credentialing



8 STEPS to Credentialing



Common Roadblocks

- Incomplete applications
- Incorrect information on application
- Expired documentation
- Differentiation of Individual and Group NPI
- Follow-up on application status

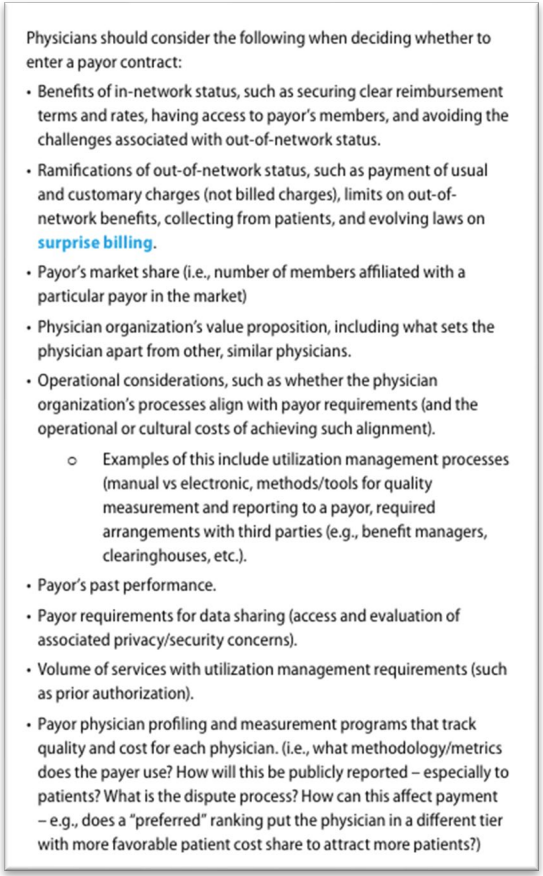
Basics of Payer Contracting

- **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 instead of with an insurer. ERISA plans are usually exempt from state insurance laws (e.g., prompt pay laws).
- **Third Party Administrator** – An entity that contracts with ERISA plans to administer the health plans, including claims adjudication and payment, utilization management, physician contracting, and other administrative functions necessary for plan operations.
- **Fee-for-Service Government Programs** – Medicare, Medicaid, Workers' Compensation, Veterans' Administration, etc. The terms of such plans are typically set by the government entity and there may be little room for a physician or practice to negotiate anything different.
- **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. Subject to few exceptions, care provided under an HMO is covered only if a member sees physicians within the HMO's network.
- **Preferred Provider Organization (PPO)** – A PPO is a type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of "preferred" providers. These preferred providers agree to the PPO's payment structure, or fee schedule, for services. PPOs also offer coverage for services provided by non-preferred (non-contracted) physicians.
- **Exclusive Provider Organization (EPO)** – EPOs are similar to PPOs, however, EPOs typically require members to receive services *only* from participating physicians.
- **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) physicians, but only upon a referral from a PCP.
- **Leased Network/Contracting Networks** – Physician networks are typically organized and managed by entities other than insurers. The network contracts with physicians to form a network that insurers pay to access, including self-funded plans and their TPAs.
- **Accountable Care Organization (ACO)Clinically Integrated Network (CINs)** – The voluntary networks of providers are typically organized and managed by health care providers (e.g., health systems) instead of insurers with the goal of delivering high-quality, coordinated care. The ACO or CIN may contract with insurers on behalf of the physicians and may require the physician to adhere to ACO or CIN clinical guidelines for care.
- **Health Care Sharing Ministries** – A nonprofit ministry that solicits contributions for sharing of health care costs among members. Health Care Sharing Ministries are not "insurers" but are recognized under the Affordable Care Act as satisfying the requirement for individual coverage.

Private Practice Toolkit: Payor Contracting 101 (PDF)

Contracting Considerations

- Volume of payer's members in your market
- Understand ramifications of out-of-network status
- Practice priorities
- Practice's unique approach and value proposition
- Payer's past performance



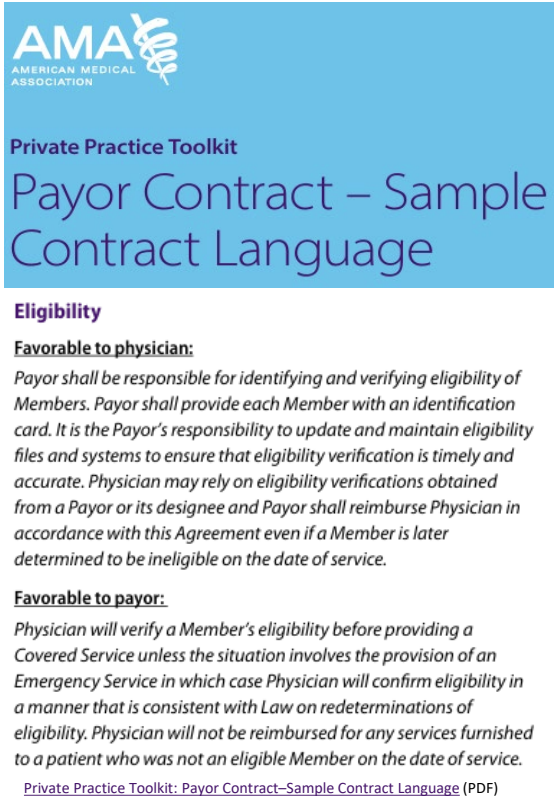
Physicians should consider the following when deciding whether to enter a payor contract:

- Benefits of in-network status, such as securing clear reimbursement terms and rates, having access to payor's members, and avoiding the challenges associated with out-of-network status.
- Ramifications of out-of-network status, such as payment of usual and customary charges (not billed charges), limits on out-of-network benefits, collecting from patients, and evolving laws on **surprise billing**.
- Payor's market share (i.e., number of members affiliated with a particular payor in the market)
- Physician organization's value proposition, including what sets the physician apart from other, similar physicians.
- Operational considerations, such as whether the physician organization's processes align with payor requirements (and the operational or cultural costs of achieving such alignment).
    - Examples of this include utilization management processes (manual vs electronic, methods/tools for quality measurement and reporting to a payor, required arrangements with third parties (e.g., benefit managers, clearinghouses, etc.).
- Payor's past performance.
- Payor requirements for data sharing (access and evaluation of associated privacy/security concerns).
- Volume of services with utilization management requirements (such as prior authorization).
- Payor physician profiling and measurement programs that track quality and cost for each physician. (i.e., what methodology/metrics does the payer use? How will this be publicly reported – especially to patients? What is the dispute process? How can this affect payment – e.g., does a "preferred" ranking put the physician in a different tier with more favorable patient cost share to attract more patients?)

Private Practice Toolkit: Payor Contracting 101 (PDF)

Important Contract Terms

- Eligibility
  - Protection from retro-eligibility changes
- Medical Necessity
  - Be wary of definitions that are overly restrictive, give blanket discretion, or include a technical component
  - Ensure definition considers aspects specific to patient conditions and services provided
- Authorization
  - Ensure your processes, timing and documentation meet payer's requirements, or mutually revise terms terms for process
  - Seek protection for unauthorized services by adding retrospective review for medical necessity process rather than technical denial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Payor Contract – Sample Contract Language

Eligibility

Favorable to physician:

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. Physician may rely on eligibility verifications obtained from a Payor or its designee and Payor shall reimburse Physician in accordance with this Agreement even if a Member is later determined to be ineligible on the date of service.

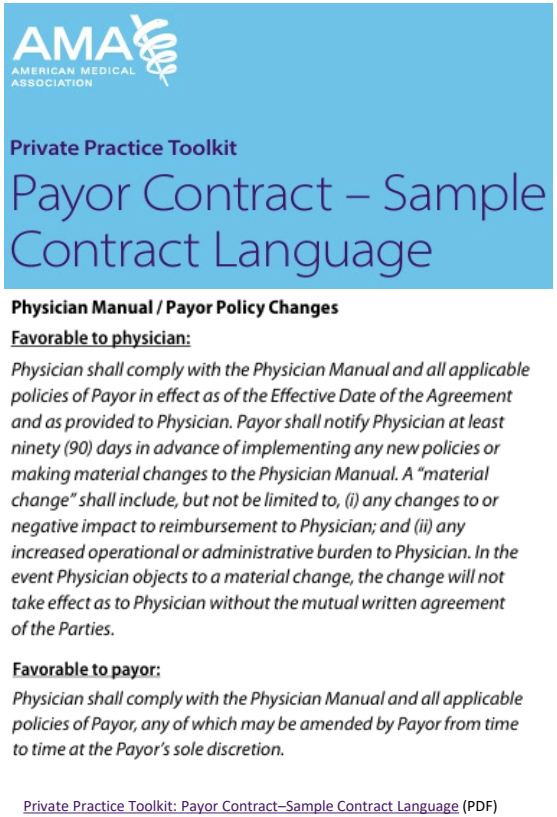
Favorable to payor:

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

Private Practice Toolkit: Payor Contract–Sample Contract Language (PDF)

Important Contract Terms

- Service Locations
  - Clearly include applicable locations of offices/clinics in agreement
- Policies & Provider Manuals
  - Understand external contract documents
  - Contract terms prevail over manuals
  - Guard against unilateral changes of material terms that impact reimbursement or increase resource obligations
  - Require written notice, opportunity to object, no amendment without mutual execution, or process to make whole
- Patient Responsibility & Non-Covered Services
  - Clearly specifies and permits patient responsibility without special conditions
  - Experimental/investigational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Payor Contract – Sample Contract Language

Physician Manual / Payor Policy Changes

Favorable to physician:

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

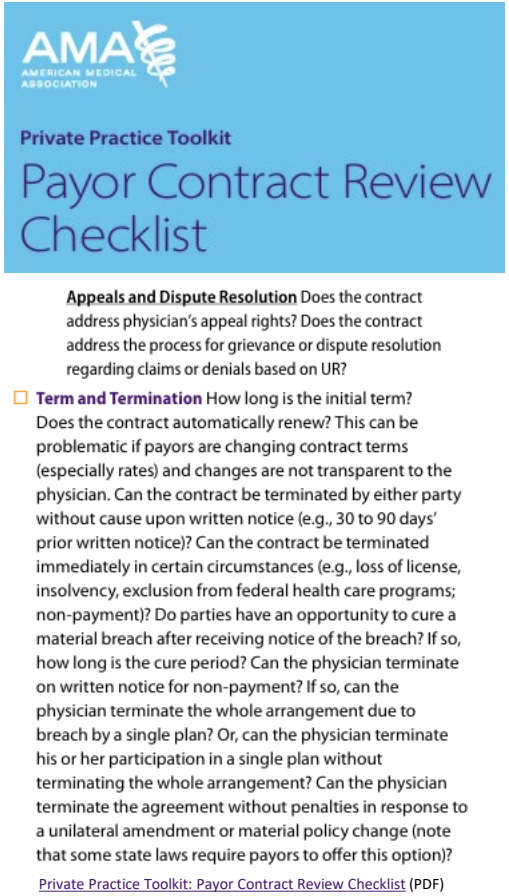
Favorable to payor:

Physician shall comply with the Physician 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.

Private Practice Toolkit: Payor Contract–Sample Contract Language (PDF)

Important Contract Terms

- Audits
  - Negotiate terms, standards, process and scope
  - Timing
  - Prerequisites
- Termination Rights
- Appeals and Dispute Resolution
  - Avoid technical pre-conditions to dispute resolutions
  - Avoid contractually shortened statues of limitations



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Payor Contract Review Checklist

Appeals and Dispute Resolution Does the contract address physician's appeal rights? Does the contract address the process for grievance or dispute resolution regarding claims or denials based on UR?

☐ **Term and Termination** How long is the initial term? Does the contract automatically renew? This can be problematic if payors are changing contract terms (especially rates) and changes are not transparent to the physician. Can the contract be terminated by either party without cause upon written notice (e.g., 30 to 90 days' prior written notice)? Can the contract be terminated immediately in certain circumstances (e.g., loss of license, insolvency, exclusion from federal health care programs; non-payment)? Do parties have an opportunity to cure a material breach after receiving notice of the breach? If so, how long is the cure period? Can the physician terminate on written notice for non-payment? If so, can the physician terminate the whole arrangement due to breach by a single plan? Or, can the physician terminate his or her participation in a single plan without terminating the whole arrangement? Can the physician terminate the agreement without penalties in response to a unilateral amendment or material policy change (note that some state laws require payors to offer this option)?

Private Practice Toolkit: Payor Contract Review Checklist (PDF)

Important Contract Terms

- Addition of New Facilities/Physicians or Acquisitions
  - Terms that support growth/expansion
  - Auto-addition upon notice and completion of credentialing
  - Contract rates for acquisition of another contracted provider? For how long?
- Payment Terms
  - Claim submission and payment timeframes, content of clean or complete claim, interest on late claims, billing codes, coding edits
  - Overpayments and offsets
  - Avoid payer unilateral right to modify reimbursement

☐ **Payment Provisions**

Late Payments or Non-Payment What are the remedies or penalties for late payments (e.g., late fees, interest, etc.)? Can a physician easily identify nonpayment/underpayment? How can a physician directly enforce payment?

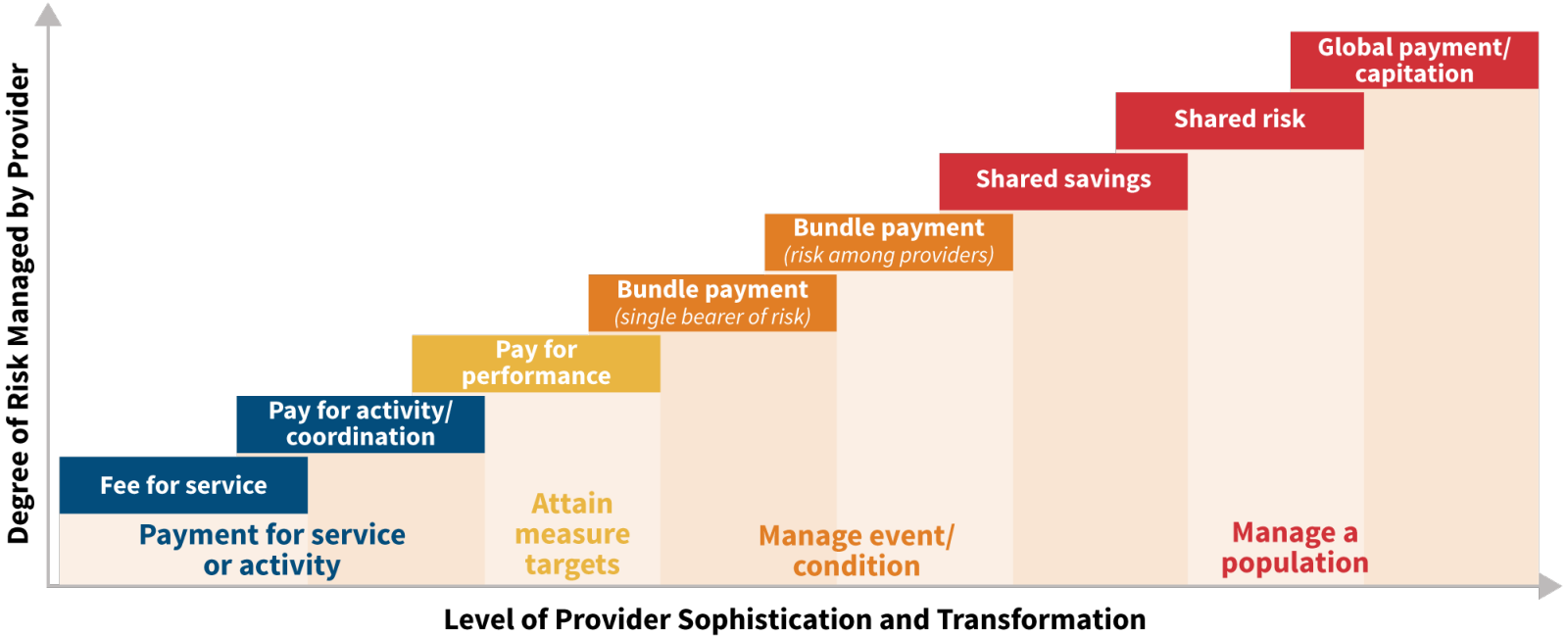
Payment methodology Does the contract specify within how many days the payor must pay the physician? Does the contract incorporate any state prompt-pay laws? What billing forms must be used? What constitutes a clean claim? Does the contract require physicians to accept electronic payments (vs. paper checks)? Does the contract require the provider to accept virtual credit cards for payment, or to contract with any third-party EFT payment processors? Are there fees associated with receiving payments through VCC or EFT?

Private Practice Toolkit: Payor Contract Review Checklist (PDF)

Contracting Trends

- Commercial payers implementing VBC arrangements
- Looking to the physician to accept more responsibility and risk
- Models that address non-medical matters such as social determinants of health, housing instability, food insecurity, social isolation
- Requires collaboration with other physicians and payers (individual, organizational, or regional levels)
- Continued push to drive down costs in health care
- Population Health through proactive care coordination/case management and clinically integrated networks (CINs)

Common VBC Approaches



https://www.theactuarymagazine.org/value-based-care-framework/

AMA Credentialing and Contracting Resources

- Payor Contracting 101 (Webinar)
- Payor Contracting 201 (Webinar)
- Private Practice Toolkit: Examples of Significant Payor Unilateral Policy Changes (PDF)
- Private Practice Toolkit: Payor Contract Review Checklist (PDF)
- Private Practice Toolkit: Payor Contract–Sample Contract Language (PDF)
- Private Practice Toolkit: Payor Contracting 101 (PDF)

Questions?

Thank you!

Physicians' powerful ally in patient care