TRILOGY
REVENUE CYCLE

Contracting with Medicare Advantage Plans

Arkansas HFMA

January 26, 2023

Legal Disclaimer

The information contained in this presentation is provided for informational purposes only, and should not be construed as legal advice on any subject matter.

You should not act or refrain from acting on the basis of any content included in this presentation without seeking legal or other professional advice.

Agenda

I. Sections of an Agreement
II. Denial Issue Categories
III. Language Issue Examples
IV. Language Issue Resolution
V. Strategies

Sections of an Agreement

Recital – Defines parties, why contracting, sometimes effective date. Location: Top of page 1.

Definitions – Defines terms. These are often difficult to edit. Payors sometimes try to slip in language that is not relevant to the definition to allow denials through the definition. Try to limit edits in definitions to this issue. Address most edits elsewhere in the agreement. Location: Immediately after Recital.

Sections of an Agreement

Scope of the Agreement – May give insight into products, plan, services included / excluded. Location: Middle.

Provider Responsibilities, Plan Responsibilities – Lots of denial implications: Location: Middle.

Utilization Management, Policies and Procedures – Denial implications: Location: Middle.

Claims Payment / Compensation – Denial implications: Location: Middle.

Sections of an Agreement

Miscellaneous – Add edits here that don't fit in other sections or if you want to make it clear they universally apply to the agreement and not just to a specific section. Location: Last section before signature page.

Product Attachments – Review for language that might override previous language. Location: After the signature page.

Reimbursement Attachments – Review for language that might override previous language. Location: After the signature page.

Denial Issue Categories

I. Redefining Non-Covered Services as "not Medically necessary"

II. Payor can change the contract and/or rules without the provider agreeing, understanding, or having the appropriate time to implement the requirement.

III. Retroactive Eligibility

IV. Retroactive Medical Necessity determinations

V. Technical Denials - Provider fails an administrative requirement and claim is denied when plan was not financially harmed

VI. Service Care Outs

VII. Plan not held accountable to perform their obligations. Need a financial remedy to motivate the payor, not just the ability to terminate the agreement.

Language Issue

Clean Claims Definition – Payor tries to slip in wording that is not part of the definition.

"Clean Claim" means a claim for Covered Services that is (i) received timely by Plan, (ii) is on a completed, legible CMS 1500 form or UB 04 form, or electronic equivalent, (iii) is true, complete, accurate, and includes all necessary supporting documentation, (iv) includes all relevant information necessary to comply with Laws and Program Requirements and to determine payor liability, (v) is not subject to coordination of benefits, and (vi) is not under review for Medical Necessity. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse.

Language Issue

Carve Out Services Definition – Payor tries to slip in wording that would be in conflict with wording elsewhere in the agreement that disallows services to be carved out.

"Non-Contracted Services" means Covered Services that are (a) subject to Carve Out Agreements and not approved by Plan in advance as further described in this Agreement, or (b) provided by an Ineligible Person.

Language Issue

Deeming - Payor changes agreement Terms without provider agreeing, understanding or having adequate time to implement.

Scope. Provider shall be a Participating Provider for all Programs identified in this Agreement. In accordance with the terms of this Agreement, Plan may add Programs by giving Contracted Provider written notice of an amendment to this Agreement. Unless Contracted Provider elects not to participate in a new Program by providing written notice in 30 days to the Plan, Provider will become a Participating Provider for the new Program in accordance with the terms of this Agreement.

Language Issue

Credentialing – There are no requirements for the plan to credential timely and to include all providers that meet credentialing criteria.

Credentialing. All Providers must meet Plan's requirements of participation including, but not limited to, its Credentialing Criteria prior to participating in Plan's contracted provider networks under this Agreement. Subject to Laws and Program Requirements, (a) Plan conducts credentialing of providers before they begin providing Covered Services and re-credentialing from time to time thereafter as required for Plan's compliance with Laws, Program Requirements and accreditation standards, and Providers shall consent to and cooperate with such credentialing/re-credentialing, which may include site reviews, and (b) until successful completion of credentialing of a provider by Plan, (i) the provider shall not be added as a Participating Provider under this Agreement, and (ii) the provision of, and payment for, Plan authorized Covered Services to Members by the provider shall be subject to Plan's policies and procedures for non-participating providers. If a Governmental Authority or its agent collects credentialing information directly for use by Plan, Plan shall use the information provided by the Governmental Authority. If a Governmental Authority has not delegated credentialing to Plan, Plan shall accept and rely on the initial credentialing or re-credentialing determination of Providers by the Governmental Authority or its agent.

Language Issue

Services Available 24 hours/day, 7 days per week – Allows for denials for delayed discharges when services are not typically offered over the weekend or at night.

Standards. Providers shall provide Covered Services in accordance with Laws and generally accepted standards of medical practice, including nationally recognized clinical protocols and guidelines where available. Providers shall ensure that Covered Services are available to Members on a 24 hour/day, 7 day/week basis, except Providers who do not provide Emergency Services shall ensure that Covered Services are available to Members in accordance with standard operating hours for each Provider location and shall maintain an after-hours phone service for individuals to seek instructions in the event of an emergency.

Language Issue

Retroactive Eligibility – Payor has unlimited retroactive eligibility. Payor is NOT required to provide accurate information.

Eligibility. Except for Emergency Services, Providers shall verify Member eligibility in accordance with the Provider Manual before providing Covered Services to a Member. Plan provides member eligibility information through Plan's provider website and other means. For Emergency Services, Providers shall verify Member eligibility no later than the next business day after the Member is stabilized or the Provider learning the individual may be a Member, whichever is later. Members' eligibility status is subject to retroactive disenrollment, and Plan may, unless prohibited by Laws and Program Requirements, recoup payments for items or services provided to such individuals after the effective date of disenrollment even if such items and services were authorized by Plan.

Language Issue

Authorizations – Payor is not required to provide accurate and complete disclosure of authorization requirements. Allows for "technical denials" when payor was not harmed. Encourages plans to add ever increasing complicated, convoluted and changing authorization requirements. Allows for denial of treatment in the ED after stabilization.

Prior Authorization. Except for Emergency Services or where prior authorization is not required by the Provider Manual, Providers shall obtain prior authorization for Covered Services in accordance with the Provider Manual. Except where not permitted by Laws or Program Requirements, Plan may deny payment for Covered Services where a Provider fails to meet Plan's requirements for prior authorization.

Language Issue

Notifying Members of Non-Covered Services – Similar to the ABN process required under Medicare. How can a provider notify a member that a service is "Non-Covered" if plan says it is covered?

Non-Covered Services. Before a Provider provides items or services to a Member that are not Covered Services, Provider shall (a) inform the Member of the ***specific*** items or services that are not Covered Services and that they will not be paid for by Plan, and (b) obtain the Member's written agreement to pay for such specific items or services after being so advised. Provider may contact Plan to determine if an item or service is a Covered Service.

Language Issue

Carve Out Services – Providers should attempt to combat cherry picking or at least limit it to the services carved out and known by the provider at the time the agreement was executed. Behavioral Health is the most difficult to combat. Common ones are behavioral health, lab, radiology, PT/OT/ST, sleep studies.

Carve Out Agreements. While a Carve Out Agreement is in effect, Covered Services subject to the Carve Out Agreement shall be Non-Contracted Services and are not within the scope of this Agreement, except for (a) Emergency Services, or (b) Covered Services authorized by Plan in advance in accordance with the Provider Manual, in which cases the terms and conditions of this Agreement, including compensation, shall apply. Plan shall notify Contracted Provider of Carve Out Agreements through the Provider Manual or other notice. Upon expiration or termination of a Carve Out Agreement, Provider shall provide the Covered Services to Members that were subject to the Carve Out Agreement, subject to and in accordance with the terms of this Agreement, including compensation.

Language Issue

Clean Claims Payment– Plan has a more aggressive standard than Medicare. Time requirement is not tied to when provider becomes aware patient is a member of the Plan. Also, there is no penalty if the Plan doesn't pay timely.

Clean Claims. Providers shall prepare and submit Clean Claims to Plan within 180 days or such other time period required by Laws or Program Requirements, of the date of a Covered Service or the date of discharge from an inpatient facility, as the case may be. Unless prohibited by Laws and Program Requirements, Plan may deny payment for any claims that fail to meet Plan's submission requirements for Clean Claims or that are received after the time limit in this Agreement for filing Clean Claims.

Language Issue

Provider Manual – Plan may alter financial or operational requirements of the agreement without provider agreeing, knowing or understanding the changes?

Provider Manual. The Provider Manual supplements and is made a part of and incorporated into this Agreement, and Providers shall comply with the Provider Manual. Plan may amend the Provider Manual from time to time upon notice to Provider by posting to Plan's provider website, email or other means of notice permitted by this Agreement, provided that in the case of material revisions to the Provider Manual, Plan shall provide notice in accordance with the provisions of this Agreement regarding written notice. Changes to the Provider Manual shall become effective 15 days after such posting or notice, or such other time period required for Plan to comply with Laws, Program Requirements or accreditation standards. Providers shall have and maintain systems necessary for access to Plan's provider website, and check for revisions to the Provider Manual from time to time.

Language Issue

Utilization Management – Doesn't define criteria, require the Plan to have an adequate network for timely discharges to lower level of care, or to fully disclose pre-cert/authorization criteria prior to service.

Utilization Management. Providers shall cooperate and participate in Plan's utilization review and case management programs. Plan's utilization review/case management programs may include provisions for (a) verification of eligibility and prior authorization for Covered Services, (b) concurrent and retrospective reviews, (c) requirements regarding referrals to third party Participating Providers, and (d) corrective action plans.

Language Issue

Medical Records – Plan should pay for medical records to increase likelihood the Plan is reviewing them and not just using it as a tactic to delay payment. The language says nothing about being able to charge.

Medical Record Review. Plan shall be entitled to perform concurrent or retrospective reviews of medical records for utilization management purposes or to verify that items and services billed to or paid for by Plan were provided and billed correctly in accordance with this Agreement and the Provider Manual, or were Covered Services (including that such items and services were Medically Necessary).

Language Issue

Overpayments / Recoupments – Provider not given adequate time to review and can't object and prevent recoupment if incorrect. No time limit specified for recoupment. No penalty for erroneous recoupments.

Overpayments. Overpayment recovery shall be in accordance with Plan's Provider Manual and Providers shall refund Overpayments to Plan within 30 days (or such other timeframe as required by Laws or Program Requirements) of the Provider's receipt of notice from Plan of such Overpayments ("Notice Period") or Provider's knowledge of such Overpayment. This section regarding Overpayments shall survive expiration or termination of this Agreement. Plan shall not seek repayment of an Overpayment from a Provider beyond the time period set forth in Plan's Provider Manual, unless a longer time is required or permitted by Laws or Program Requirements. Notwithstanding anything to the contrary herein, there shall be no deadline within which Plan may seek recovery of an Overpayment in a case of fraud.

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Language Issue

Plan Outsources to Third Parties – Outsource personnel need to understand both English and U.S. healthcare industry. Audits need to be accurate and not overwhelm provider.

Plan Designees. With regard to administering Benefit Plans, Plan may delegate administrative functions to third parties, and Provider shall cooperate with such third parties to the same extent Provider is required to cooperate with Plan.

Language Issue

Force Majeure – No provision for waiving technical denials when provider or Plan may be unable to follow them.

Force Majeure. The Parties shall have and maintain disaster recovery plans in accordance with high industry standards. However, if either Party's performance under this Agreement is prevented, hindered or delayed by reason of any cause beyond the Party's reasonable control that cannot be overcome by reasonable diligence, including war, acts of terrorism, civil disorders, labor disputes (other than strikes within such Party's own labor force), governmental acts, epidemics, quarantines, embargoes, fires, earthquakes, storms, or acts of God, such Party shall be excused from performance to the extent that it is prevented, hindered or delayed thereby, during the continuances of such cause; and such Party's obligations hereunder shall be excused so long as and to the extent that such cause prevents or delays performance. If a Provider is unable to perform under this Agreement due to an event as described in this paragraph, Plan may take whatever action is reasonable and necessary under the circumstances to ensure its compliance with Laws and Program Requirements and equitably adjust payments to the Provider until the Provider resumes its performance under this Agreement.

Language Issue

Provider Relations Contact – No requirement to provide a specific provider relations contact when generic customer service contact fails to resolve an issue.

Joint Operations Committee – No requirement for routine operational meetings between the provider's and Plan's operational staff to resolve complex and/or convoluted issues that are not resolved through generic customer service channels.

Language Issue Resolution

Clean Claims Definition – Payor tries to slip in wording that is not part of the definition.

"Clean Claim" means a claim for Covered Services that is (i) received timely by Plan, (ii) is on a completed, legible CMS 1500 form or UB 04 form, or electronic equivalent, (iii) is true, complete, accurate, and includes all necessary supporting documentation, (iv) includes all relevant information necessary to comply with Laws and Program Requirements and to determine payor liability, (v) is not subject to coordination of benefits~~, and (vi) is not under review for Medical Necessity~~. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse.

Language Issue Resolution

Carve Out Services Definition – Payor tries to slip in wording that would be in conflict with wording elsewhere in the agreement that disallows services to be carved out.

"Non-Contracted Services" means Covered Services that are ~~(a) subject to Carve Out Agreements and~~ not approved by Plan in advance as further described in this Agreement, or (b) provided by an Ineligible Person.

Language Issue Resolution

Deeming - Payor can change Agreement Terms without provider agreeing, understanding or having adequate time to implement.

Scope. Provider shall be a Participating Provider for all Programs identified in this Agreement. In accordance with the terms of this Agreement, Plan may add Programs and shall give Provider option to participate by giving Contracted Provider written notice of an amendment to this Agreement. Unless Contracted Provider elects not to participate in a new Program by providing timely written notice to the Plan, Provider will become a Participating Provider for the new Program in accordance with the terms of this Agreement if the Provider accepts the amendment in writing. Plan may not deem Provider into a new Program without Provider's written agreement.

Language Issue Resolution

Credentialing – There are no requirements for the plan to credential timely and to include all providers that meet credentialing criteria.

Credentialing. All Providers must meet Plan's requirements of participation including, but not limited to, its Credentialing Criteria prior to participating in Plan's contracted provider networks under this Agreement. Subject to Laws and Program Requirements, (a) Plan conducts credentialing of providers before they begin providing Covered Services and re-credentialing from time to time thereafter as required for Plan's compliance with Laws, Program Requirements and accreditation standards, and Providers shall consent to and cooperate with such credentialing/re-credentialing, which may include site reviews, and (b) until successful completion of credentialing of a provider by Plan, (i) the provider shall not be added as a Participating Provider under this Agreement, and (ii) the provision of, and payment for, Plan authorized Covered Services to Members by the provider shall be subject to Plan's policies and procedures for non-participating providers. If a Governmental Authority or its agent collects credentialing information directly for use by Plan, Plan shall use the information provided by the Governmental Authority. If a Governmental Authority has not delegated credentialing to Plan, Plan shall accept and rely on the initial credentialing or re-credentialing determination of Providers by the Governmental Authority or its agent. Plan will accept any and all Providers as Participating Providers under the terms of this Agreement if Provider meets Plan's Credentialing criteria. Plan will complete credentialing within 90 days. The 90 days will only be stayed for the days Plan is waiting on requested information from Provider.

Language Issue Resolution

Services Available 24 hours/day, 7 days per week – Allows for denials for delayed discharges when services are not typically offered over the weekend or at night.

Standards. Providers shall provide Covered Services in accordance with Laws and generally accepted standards of medical practice, including nationally recognized clinical protocols and guidelines where available. Providers shall ensure that Covered Services are available to Members on a 24 hour/day, 7 day/week basis, except Providers who do not provide Emergency Services shall ensure that Covered Services are available to Members in accordance with standard operating hours for each Provider location and shall maintain an after-hours phone service for individuals to seek instructions in the event of an emergency. Nothing in this section is to be construed to require Provider to provide services 24 hours per day, 7 days per week during periods when those services are not provided on such basis during the normal course of business or during such time as Force Majeure may be in effect.

Language Issue Resolution

Retroactive Eligibility – Payor has unlimited retroactive eligibility. Payor is NOT required to provide accurate information.

Eligibility. Except for Emergency Services, Providers shall verify Member eligibility in accordance with the Provider Manual before providing Covered Services to a Member. Plan provides member eligibility information through Plan's provider website and other means. For Emergency Services, Providers shall verify Member eligibility ~~no~~ the later ~~than~~ of 48 hours or the next business day after the Member is stabilized or the Provider learning the individual may be a Member, whichever is later. ~~Members' eligibility status is subject to retroactive disenrollment, and Plan may, unless prohibited by Laws and Program Requirements, recoup payments for items or services provided to such individuals after the effective date of disenrollment even if such items and services were authorized by Plan.~~

Language Issue Resolution

Retroactive Eligibility

(Continue)

Plan or their designee shall be responsible for identifying and verifying eligibility of Members and providing Provider with information regarding the Member's Health Benefit for Covered Services. Plan, or its designee, shall provide each Member with an identification card. It is Plan's responsibility to update and maintain eligibility files and systems to ensure that eligibility verification is timely and accurate. Plan shall make available to Provider a process to confirm eligibility and benefits and obtain prior authorization for Members on a twenty-four (24) hour, seven (7) days per week basis. In the event Plan or their designee has verified eligibility of a patient as a Member, and later determines that such patient is not a Member, then Plan is required to pay Provider for any services provided to the ineligible patient at the rates contained herein. In the event Member fails to provide a valid identification card at the time of service and, as a result, precertification, preauthorization, preadmission, and utilization management procedures of Plan are not met, then Plan shall review such services for Medical Necessity and coverage and shall pay Provider for such Medically Necessary Covered Services. Services which are deemed not Medically Necessary or Non-Covered Services may be billed directly to Member by Provider. Provider shall not be required to refund payments related to retroactive ineligibility of Members if notification from Plan is received more than thirty (30) days from the date services were provided by Provider.

Language Issue Resolution

Authorizations – Payor is not required to provide accurate and complete disclosure of authorization requirements. Allows for "technical denials" when payor was not harmed. Encourages plans to add ever increasing authorization requirements. Allows for denial of treatment in the ED after stabilization.

Prior Authorization. Except for Emergency Services or where prior authorization is not required by the Provider Manual, Providers shall obtain prior authorization for Covered Services in accordance with the Provider Manual. If Provider follows authorization procedures outlined in this Agreement and receives an authorization from Plan or its designee to provide requested services to Member, Plan will pay Provider for such services per the reimbursement terms of this Agreement. Under no circumstances will payment for previously authorized services be denied retroactively based on a determination that the services were not Medically Necessary. ~~Except where not permitted by Laws or Program Requirements, Plan may deny payment for Covered Services where a Provider fails to meet Plan's requirements for prior authorization.~~ Treatment for Emergency Services during the same visit as the evaluation and stabilization of Emergency Services shall not require prior authorization and Plan shall not deny for failure to obtain prior authorization.

Language Issue Resolution

Notifying Members of Non-Covered Services – Similar to the ABN process required under Medicare. How can a provider notify a member that a service is "Non-Covered" if plan says it is covered?

Non-Covered Services. Before a Provider provides items or services to a Member that are not Covered Services, Provider shall (a) inform the Member of the ***specific*** items or services that are not Covered Services and that they will not be paid for by Plan, and (b) obtain the Member's written agreement to pay for such specific items or services after being so advised. Provider may contact Plan to determine if an item or service is a Covered Service and may rely on information obtained from Plan. If Plan represents to Provider that items or services are Covered Services, then Provider may rely on such information and any requirements to notify Members of Non-Covered services are waived.

Language Issue Resolution

Carve Out Services – Providers should attempt to combat cherry picking or at least limit it to the services carved out and known by the provider at the time the agreement was executed. Behavioral Health is the most difficult to combat. Can also add "Anti-Tiering" language in the section.

Carve Out Agreements. ~~While a Carve Out Agreement is in effect, Covered Services subject to the Carve Out Agreement shall be Non-Contracted Services and are not within the scope of this Agreement, except for (a) Emergency Services, or (b) Covered Services authorized by Plan in advance in accordance with the Provider Manual, in which cases the terms and conditions of this Agreement, including compensation, shall apply. Plan shall notify Contracted Provider of Carve Out Agreements through the Provider Manual or other notice. Upon expiration or termination of a Carve Out Agreement, Provider shall provide the Covered Services to Members that were subject to the Carve Out Agreement, subject to and in accordance with the terms of this Agreement, including compensation.~~ Plan agrees that Hospital may provide and shall be reimbursed for all Covered Services provided to Members. Plan agrees to allow all Hospital services to be used by Members and shall not carve out or redirect any services that are offered by Provider. All services capable of being provided at Provider will be permitted to be provided by Provider, at the highest benefit level to the Member, and only with Provider's prior written approval will Plan redirect Members residing in Provider's service area to other providers of similar services.

Language Issue Resolution

Clean Claims Payment– Plan has a more aggressive standard than Medicare. Time requirement is not tied to when provider becomes aware patient is a member of the Plan. Also, there is no penalty if the Plan doesn't pay timely.

Clean Claims. Providers shall prepare and submit Clean Claims to Plan within ~~180~~ 365 days or such other time period required by Laws or Program Requirements, of the date of a Covered Service or the date of discharge from an inpatient facility, as the case may be. In the event Member did not identify themself as a Member of Plan, Provider has 180 days from such time as becoming aware patient is a Member of Plan. Claims not paid from the receipt of the initial clean claim in excess of 30 days for electronically filed claims and 45 days for paper claims will be due interest payments of 12% per annum for the total days not paid from the receipt of the initial clean claim in excess of 30 days for electronically filed claims and 45 days for paper claims. Interest is due and payable without request from Provider. Unless prohibited by Laws and Program Requirements, Plan may deny payment for any claims that fail to meet Plan's submission requirements for Clean Claims or that are received after the time limit in this Agreement for filing Clean Claims.

Language Issue Resolution

Provider Manual – Plan may alter financial or operational requirements of the agreement without provider agreeing, knowing or understanding the changes?

Provider Manual. The Provider Manual supplements and is made a part of and incorporated into this Agreement, and Providers shall make reasonable efforts comply with the Provider Manual. Plan may amend the Provider Manual from time to time upon notice to Provider by posting to Plan's provider website, email or other means of notice permitted by this Agreement, ~~provided that in the case of material revisions to the Provider Manual, Plan shall provide notice in accordance with the provisions of this Agreement regarding written notice. Changes to the Provider Manual shall become effective 15 days after such posting or notice, or such other time period required for Plan to comply with Laws, Program Requirements or accreditation standards. Providers shall have and maintain systems necessary for access to Plan's provider website, and check for revisions to the Provider Manual from time to time.~~

Language Issue Resolution

Provider Manual

(Continue)

Plan shall provide sixty (60) days advance written notice to Provider of any changes to policies, procedures and networks that will have a material impact on this Agreement. For purposes of this provision, material impact includes, but is not limited to, 1) placing additional administrative requirements on the Provider, 2) changing the Provider's status as a participating provider in one of Plan's networks, or excluding one or more of the Provider's services from being able to be accessed by Members or 3) the implementation of a policy or procedure that will negatively impact the Provider's revenue stream from Plan or 4) a change that will alter the payment or reimbursement arrangements as agreed to between the parties under this Agreement. For purposes of this Agreement, a material change in revenue will be defined as an impact which exceeds three thousand dollars ($3,000) on an annual revenue or cost basis, as determined by Provider. A material impact will also be defined as a change which causes the Provider to deploy additional human and operational resources to comply with any procedure or policy, as determined by the Provider. In the event Plan does not provide notice of a change with a material impact as defined here, then such change shall not be effective as to Provider. Provider shall have 60 days from the date of receipt of any notice to notify Plan that it objects to the change. In the event of Provider's objection, the parties shall meet and renegotiate the compensation as specified in this Agreement in order to make Provider whole for the impact (increased cost or revenue reduction) of such change. If the parties cannot reach agreement to an adjusted compensation, then the revisions and changes will not apply to Provider. In the event of any conflict between a Plan policy or procedure, and the terms of this Agreement, then the terms of this Agreement shall supersede. Plan represents and warrants it shall follow Plan's Provider Manual and other Plan policies and procedures where Plan's failure to do so may harm provider.

Language Issue Resolution

Utilization Management – Doesn't define criteria, require the Plan to have an adequate network for timely discharges to lower level of care, or to fully disclose pre-cert/authorization criteria prior to service.

Utilization Management. Providers shall cooperate and participate in Plan's utilization review and case management programs. Plan's utilization review/case management programs may include provisions for (a) verification of eligibility and prior authorization for Covered Services, (b) concurrent and retrospective reviews, (c) requirements regarding referrals to third party Participating Providers, and (d) corrective action plans. Plan represents and warrants Provider's use of InterQual for determination as to what constitutes and appropriate inpatient admission. In the event Provider informs Plan of Member meeting discharge criteria from the current level of care to a lessor level and Provider is unable or Plan fails to transfer Member to the appropriate level of care within 23 hours, Plan will reimburse Provider an additional $1,200 per day in addition to any other reimbursement due to provider when such reimbursement is based on a case rate or other fixed payment rate that is unaffected by length of stay.

Language Issue Resolution

Medical Records – Plan should pay for medical records to increase likelihood the Plan is reviewing them and not just using it as a tactic to delay payment. The language says nothing about being able to charge.

Medical Record Review. Plan shall be entitled to perform concurrent or retrospective reviews of medical records for utilization management purposes or to verify that items and services billed to or paid for by Plan were provided and billed correctly in accordance with this Agreement and the Provider Manual, or were Covered Services (including that such items and services were Medically Necessary). Provider may charge up to state maximum for medical records provided to Plan or its designee.

Language Issue Resolution

Overpayments / Recoupments – Provider not given adequate time to review and can't object and prevent recoupment if incorrect. No time limit specified for recoupment. No penalty for erroneous recoupments.

Overpayments. ~~Overpayment recovery shall be in accordance with Plan's Provider Manual and Providers shall refund Overpayments to Plan within 30 days (or such other timeframe as required by Laws or Program Requirements) of the Provider's receipt of notice from Plan of such Overpayments ("Notice Period") or Provider's knowledge of such Overpayment. This section regarding Overpayments shall survive expiration or termination of this Agreement. Plan shall not seek repayment of an Overpayment from a Provider beyond the time period set forth in Plan's Provider Manual, unless a longer time is required or permitted by Laws or Program Requirements.~~

Language Issue Resolution

Overpayments / Recoupments

(continue)

In no event shall Plan offset overpayments against, or deduct overpayments from any other payments it owes to Provider unless Provider expressly and in writing permits Payer to do so. Payer agrees that all requests for retroactive reductions of payments or demands for refund of previous overpayments must be submitted in writing to the Overpayment Request Address below and can be reconciled to the specific claim through the identification of the following information: patient name, Member identification number, date(s) of service, type of service, amount paid, amount of overpayment, and specific and detailed reason for overpayment. Overpayments identified to Provider by Plan beyond the lesser of 30 days from payment or one (1) year from the date of service are invalid and Plan shall not be entitled to any refund from Provider. Plan represents and warrants recoupments are in accordance with this Agreement. Any erroneous recoupments are subject to interest payments of 12% per annum for the total days not paid from the receipt of the initial clean claim in excess of 30 days for electronically filed claims and 45 days for paper claims. Interest is due and payable without request from Provider. Notwithstanding anything to the contrary herein, there shall be no deadline within which Plan may seek recovery of an Overpayment in a case of fraud.

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Language Issue Resolution

Plan Outsources to Third Parties – Outsource personnel need to understand both English and U.S. healthcare industry. Audits need to be accurate and not overwhelm provider.

Plan Designees. With regard to administering Benefit Plans, Plan may delegate administrative functions to third parties, and Provider shall cooperate with such third parties to the same extent Provider is required to cooperate with Plan. Third parties must speak English as their primary language. Provider is not required to interface or otherwise communicate with third parties when such parties are performing audits. Plan will not engage third party audits for Provider claims where the third party is contingency based, or otherwise financially motivated to deny and/or reduce payment to Provider.

Language Issue Resolution

Force Majeure – No provision for waiving technical denials when provider or Plan may be unable to follow them.

Force Majeure. The Parties shall have and maintain disaster recovery plans in accordance with high industry standards. However, if either Party's performance under this Agreement is prevented, hindered or delayed by reason of any cause beyond the Party's reasonable control that cannot be overcome by reasonable diligence, including war, acts of terrorism, civil disorders, labor disputes (other than strikes within such Party's own labor force), governmental acts, epidemics, quarantines, embargoes, fires, earthquakes, storms, or acts of God, such Party shall be excused from performance to the extent that it is prevented, hindered or delayed thereby, during the continuances of such cause; and such Party's obligations hereunder shall be excused so long as and to the extent that such cause prevents or delays performance. If a Provider is unable to perform under this Agreement due to an event as described in this paragraph, Plan may take whatever action is reasonable and necessary under the circumstances to ensure its compliance with Laws and Program Requirements and equitably adjust payments to the Provider until the Provider resumes its performance under this Agreement. In the event Provider makes a good faith effort to comply with this Agreement or is unable to comply, Plan will not deny payment solely on the grounds of Provider's noncompliance during a time of force majeure. This includes but is not limited to Utilization Review, Payer/Plans payment policies or processes, authorization requirements, pre-certification requirements, timely filing or other administrative requirements that could not be reasonably performed by Provider.

Language Issue Resolution

Provider Relations Contact – No requirement to provide a specific provider relations contact when generic customer service contact fails to resolve an issue.

Provider Relations Contact. Plan shall assign a specific provider relations representative to work with Provider in resolving issues between the two parties. A generic e-mail address, customer service number, web portal request/contact form, or other inquiry method not identifying a specific contact person from the Plan does not fulfill Plan's requirement to provide a specific provider relations contact.

Language Issue Resolution

Joint Operations Committee – No requirement to routine calls with the provider's operational staff and the Plan to resolve complex and/or convoluted issues that are not resolved through generic customer service channels.

Joint Operations Committee (JOC). Plan agrees to meet either remote or in person no less than monthly, unless both parties agree otherwise, to resolve operational issues. Plan shall have appropriate staff available to discuss and/or resolve issues.

Strategies

I. Negotiate language first, then rates – Can't price agreement without first understanding operational, denial and bad debt exposure. Leverage payor refusal to address language issues with increased pricing.

II. Edit existing language where possible instead of rewriting sections.

III. Ensure remedies are in the agreement to motivate payor to abide by the agreement.

IV. Be able to articulate
   A. The issue you are trying to resolve
   B. Your rationale to the payor
   C. As an example or story

Questions?

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TRILOGY
A HEALTHCARE SOLUTIONS COMPANY
REVENUE CYCLE
HEALTHCARE MANAGEMENT
POPULATION HEALTH