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REVENUE CYCLE RESOURCES

Navigating Payor Contracting

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What's Out There?

- Medicare Advantage
- Medicaid MCOs
- Commercial Insurance Payors
- Reference Based Plans
- Network Only
- Single Case Agreements
- Deemed Upon Admission

Current Landscape

- Medicare Advantage Activity
- Push for Current Agreements to be Renegotiated
  - “Old Paper”
  - Pricing Transparency
- Emerging “Network Only” Agreements
- Agreement Extensions
- Sneaky Fine Print via Fax/Email (Single Case Agreements)
- Stricter Enforcement of Charge Increase Language
- New & Ridiculous Reimbursement Language
- The “By Published Policy” Liberty Loophole

Agreement Language

- **General**
  - Keep Medicare, Medicaid & Commercial separate when possible
- **Reimbursement**
  - Review for Cost-to-Charge Ratio, PerDeim, DRG, or PPS models
  - Be Cautious of “Lesser of” Clause
  - Watch for Carve Out of Limit on Services (Facility Fee, Reference Lab)
  - Require Rebuttal Time for Offsets & Recoupments
  - Carefully review revenue code charts included in terms

Utilization Review- Key Language

- Verify Notification and Authorization Requirements
  - Ensure Clarity on timing, method, and payor response deadline

- Level of Care –Rebilling
  - Allow inpatient-to-observation rebills when inpatient is denied by observation is appropriate
  - Especially for post-discharge, non-timely determinations

  - Suggested Language "If an inpatient admission is denied for lack of medical necessity, but the services meet Medicare criteria for observation care, the hospital may rebill as observation—regardless of the original inpatient order."

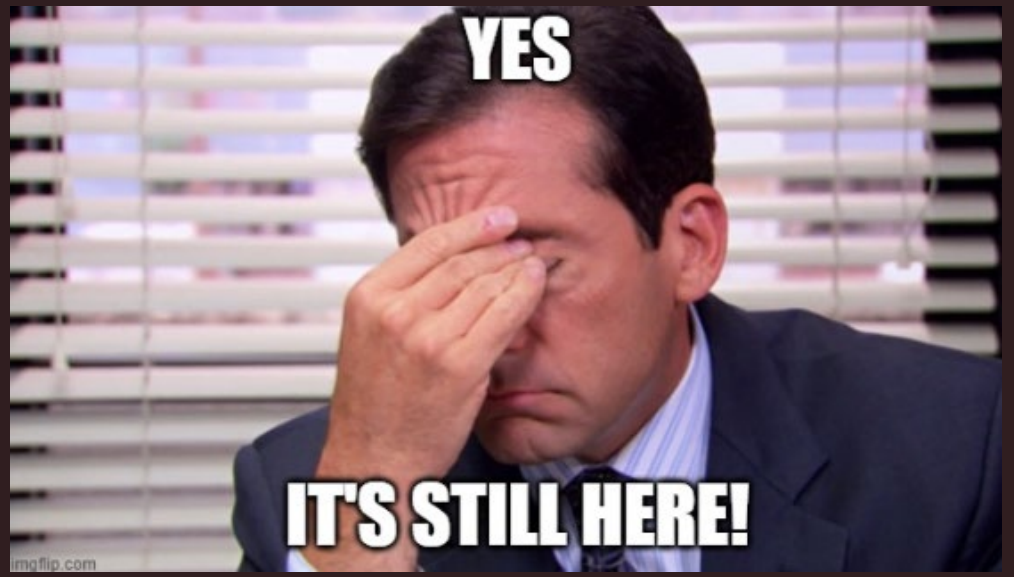
Claims- Key Terms to Include

- Timely Filing
  - Request 1 year from date of service
- Post-Payment Audits
  - Define audit limits and allow 180+ days to be rebilled after an adverse determination
- Appeal Timeframes
  - May default to payor policy (not contract)
  - Base timelines on denial/payment date, not date of service
- Disputed/Adjusted Claims
  - Request 365-day resolution window
- Audit & Appeals Process
  - Clearly define rights, responsibilities, and timelines

Agreement Language

- **Professional Fees**
  - Avoid non-descriptive, proprietary fee schedules
  - Ensure fair reimbursement for unlisted codes (e.g.,% of charges)
- **Other**
  - Payor access to records– Define scope, purpose, and notice requirements
  - Acquired or Merged Services- Clarify impact on reimbursement rates
  - Chargemaster limits- Watch for caps, reporting requirements & reimbursement implications
  - Term & Termination- Confirm notice period, cause definitions, and renewal terms
  - Third Party Lease or Extension- Prevent rates from being extended without approval

Medicare Advantage



Medicare Advantage- Informational Links

Medicare Penetration by County

State Name	County Name	FIPSST	FIPSCNTY	FIPS	SSAST	SSACNTY	SSA	Eligibles	Enrolled	Penetration
Nebraska	Adams	31	1	31001	28	0	28000	7,040	2,252	31.99%
Nebraska	Antelope	31	3	31003	28	10	28010	1,666	382	22.93%
Nebraska	Arthur	31	5	31005	28	20	28020	109	12	11.01%
Nebraska	Banner	31	7	31007	28	30	28030	268	23	8.58%
Nebraska	Blaine	31	9	31009	28	40	28040	119	11	9.24%
Nebraska	Boone	31	11	31011	28	50	28050	1,453	487	33.52%

Plans Offered by County 2025

- List of Plans offered by County

✅ Do's – Include in Medicare Advantage

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✅ **Cost Report Settlement**
- Consider creative language in lieu of (360 Rev Code paid on OP Rate)

✅ **CRNA Passthroughs, Method II, AIR Rate, and IP/OP Reimbursement**
- Spell out each item clearly to ensure correct processing

❌ Do not allow “lesser of” language

✅ **RHC**
- Address items typically included in the cost report, such as vaccines and nurse-only visits

✅ **3-Day Bundling Exemption**
- Preserve the ability to bill inpatient and outpatient services separately

❌ Don’ts – Avoid in Medicare Advantage

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❌ **Per Diem Limits**
- Avoid restrictions on maximum days billed under per diem models

❌ **510 Revenue Code Carve Outs**
- Prevent payors from excluding key facility services

❌ **Undefined Proprietary Professional Fee Schedules**
- Only accept clearly defined and transparent professional fee terms

❌ **Selective Fee Schedule Language (Lab/Radiology)**
- Watch for language that suppresses reimbursement for specific services

❌ **Chargemaster Increase Limits**
- Avoid provisions that cap hospital charge increases unfairly

❌ **Silent on Sequestration**
- Do not allow silence on sequestration—Medicare Advantage plans are not subject to it

Other MA Language Considerations

- **Rate Update Timing**
  - Clarify when Medicare updates will be loaded upon notification
  - Assign internal responsibility for sending updated rate letters
- **Request reimbursement above Medicare fee schedules/rates**
  - (i.e., 110% of MPFS or Hospital OP rate)
- **Timely Filing**
  - Negotiate a one-year timely filing to align with Medicare

MOVING ON!

Network Only & Extension Agreements

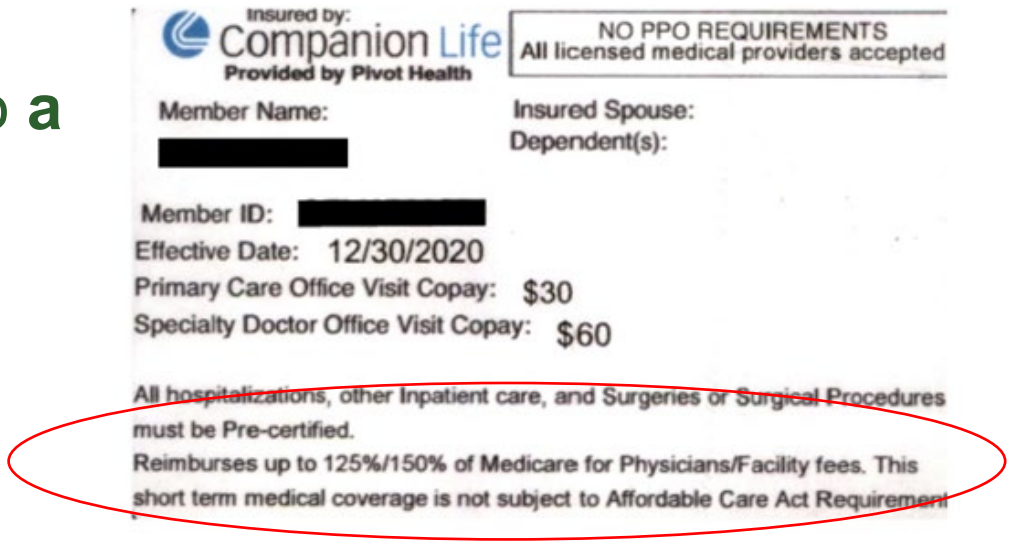
- **Network Only**
  - New Start-up Networks
  - Rates look okay, but the fine print…
    - Access to Network-Workcomp, Liability, Auto
    - Subject to Individual Payor Policy
    - Varied Rates per Payor
- **Network Extension**
  - Commercial to Commercial-(United & Aetna)
  - Workcomp, Liability, Auto
  - Silent PPOs

Single Case Agreements: Know the Risks

- **Don’t be lured by “Prompt Payment”**
- **Be firm: Hard No or Nominal Discount**
- **Watch for Hidden “Tricks”**
  - Deemed Participation – You may unknowingly agree to terms by:
    - Accepting an Insurance Card at Registration
    - Cashing a Check
    - Signing Anything

“Deemed” Participation

- **Insurance Card or Remittance = Agreement?**
  - Some payors include fine print that says **cashing the check or accepting the card means you accept their terms**
- **Fine Print = Long-Term Commitment**
  - What looks like a one-time deal could bind you to **a recurring agreement**


Insured by:
Companion Life
Provided by Pivot Health

NO PPO REQUIREMENTS
All licensed medical providers accepted

Member Name:
[redacted]

Insured Spouse:
Dependent(s):

Member ID: [redacted]
Effective Date: 12/30/2020
Primary Care Office Visit Copay: $30
Specialty Doctor Office Visit Copay: $60

All hospitalizations, other Inpatient care, and Surgeries or Surgical Procedures must be Pre-certified.
Reimburses up to 125%/150% of Medicare for Physicians/Facility fees. This short term medical coverage is not subject to Affordable Care Act Requirement

Reference Based Plans (RBP) Proceed with Caution

- Self-Insured Plans using “creative pricing” model
- Classified as insurers under Nebraska law
- Must comply with NO Surprises Act
- Frequently rely on “deemed participation” tactics
- Reimbursement rates are typically well below Medicare or commercial rates

Best Practices

- Engage a Multidisciplinary Team in Contracting Decisions
- Maintain Clear Documentation of Contract Decisions
- Ensure Contract Matrix is Transparent and Accessible to All Stakeholders
- Assign Ownership for Updating Medicare Rate Letters