

Session Three – The Provider Contracting Process

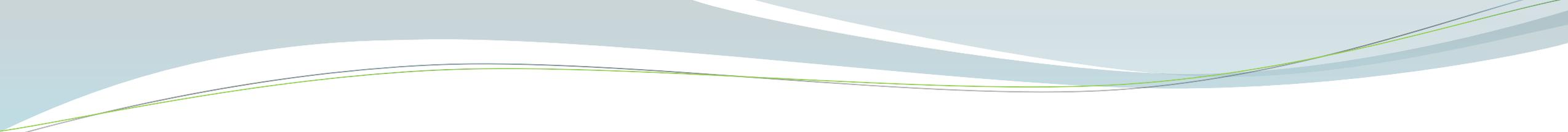
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Beth Berendt, Berendt and Associates, LLC

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Did you participate in previous sessions?

Session Overview

- Introduction and review of key terms
- Health Issuers offering QHPs for 2014
- Proposed QHPs for 2015
- Health Issuers in the “Outside Market” 2014 & Proposed for 2015
- Sub-contracted Networks – or “Rented Networks”
- OneHealthPort – An important part of the process
- Getting started – Registering with OneHealthPort and Contacting Provider Relations
- Helpful links to Issuer’s Provider Services
- Reviewing the Contract
- The Provider Administrative Manual -
- Compensation Agreements –
- Amending the Provider Contract or Compensation Agreements
- Questions

Key Terms

- Essential Community Provider” -are providers that serve predominantly low-income, medically underserved populations and in Washington State – The Insurance Commissioner defines and Essential Community Provider under WAC 284-43 -221 see: <http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-221> -
- “Health Benefit Plan” – The health coverage product defined by the:
 - covered services (Essential Health Benefits plus any additional benefits added by the issuer)
 - the limitations/exclusions,
 - the cost sharing (deductible, copays & coinsurance); and
 - Network
- “Issuer” – the type of health carrier that provides the health care coverage- In Washington there are 3 different types of issuers:
 - Health Care Service Contractor - such as Premera BlueCross, Regence BlueShield
 - Health Maintenance Organization (HMO) such as Group Health Cooperative
 - Disability Insurance Company – such as United Healthcare and Aetna

Key Terms

- “Outside Market” – Term of art to describe the individual, small group and large group health benefit plans (products) that are sold by issuers outside of the Health Benefit Exchange (Washington Healthplanfinder.) The individual and small group products **are not** Qualified Health Plans (QHPs) or “Apple Health” – Managed Care Medicaid plans
- “Provider Credentialing” or “Credentialing” is a systematic approach to the collection and verification of a provider's professional qualifications. The qualifications that are reviewed and verified include, but are not limited to, relevant training, licensure, certification and/or registration to practice in a health care field, and academic background. The issuer may also conduct an assessment of whether the provider meets certain criteria relating to professional competence and conduct.

Key Terms

- “Qualified Health Plan” or “QHP” – an individual or small group health benefit plan that is Certified by the Health Benefit Exchange Board and purchased through Washington Healthplanfinder. QHPs are not issued to Medicaid beneficiaries or in the “outside” market
- “Service Area” the geographic area or areas where a specific product is issued, accepts members or enrollees, and covers provided services. A service area must be defined by the county or counties unless the commissioner permits limitation of a service area by zip code due to geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable



When does 2015 Open Enrollment for individuals and small groups occur?

Health Issuers – 2014 & 2015 Plan Years

- The following slides present information for the QHPs for 2014 plan year and preliminary information for 2015
- The 2015 issuer's, products, service areas, rates and certification by the Health Benefit Exchange (if applicable) will occur between now and mid September 2014
- All individual and small group products (QHPs and Outside Market) for 2015 must be finalized by mid September to meet the open enrollment deadlines
- Open enrollment for individual and small groups in 2015 occurs November 15, 2014 to February 15, 2015
- All information about 2015 is preliminary and subject to approval by the Insurance Commissioner and Health Benefit Exchange Board

The Health Issuers – 2014 & proposed 2015 Qualified Health Plans - Individual

Issuer –	Service Area by County for 2014 – may change in 2015	Year	2014 Apple Health Medicaid Plan?
Bridgespan (a Cambia company)	King, Kitsap, Pierce, Skagit, Snohomish, Thurston & Spokane	2014 2015 if certified	No
Community Health Plan of Washington	Adams, Benton, Chelan, Clark, Cowlitz, Douglas, Ferry , Franklin, Grant, Grays Harbor, King, Kitsap, Lewis, Okanogan, Pacific, Pend Oreille, Pierce, Skagit, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom & Yakima	2014 2015 if certified	Yes
Group Health Cooperative	Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman & Yakima	2014 2015 if certified	No – subcontracts with Community Health Plan
Lifewise Health Plan of Washington (a Premera company)	All 39 counties	2014 2015 if certified	No

The health issuers – and the markets they serve 2014 Qualified Health Plans - Individual

Issuer	Service Area by county for 2014 -may change for 2015	Year	2014 Apple Health Medicaid Plan?
Molina Healthcare of Washington	King, Pierce and Spokane	2014 2015 if certified	Yes
Premera Blue Cross	All counties except Clark	2014 2015 if certified	No
Kaiser Foundation Health Plan of Northwest	Clark and Cowlitz	2014 2015 if certified	Yes

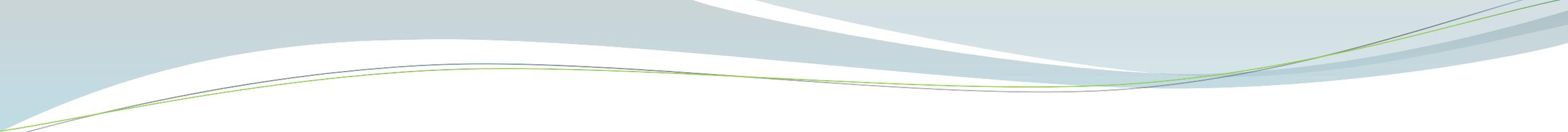
WA APPLE HEALTH Service Areas Effective May 1, 2014

<http://www.hca.wa.gov/medicaid/healthyoptions/Documents/5-1-2014%20HO-CHIP-HOBD-HOFC-AHAC%20Programs%20MAP%204-23-14ab.pdf.pdf>

New Qualified Health Plans for 2015 – Pending Approval and Certification

In addition to all of the 2014 QHPs the following issuers have submitted filings for approval by the OIC and certification by the Health Benefit Exchange for 2015

Issuer	Possible Service Area	2014 Apple Health (Medicaid Plan?)
Columbia United Providers	Clark	No – but subcontracts with Community Health Plan for 2014 May be Apple Health Plan for 2015 if accepted by HCA
Health Alliance Northwest Health Plan, Inc.	Chelan, Douglas, Grant & Okanogan	No
UnitedHealthCare of Washington	TBD – Statewide?	Yes
Moda Health Plan, Inc.	TBD -Statewide?	No



True or False

Health plans sold in the “outside” market are required to provide Essential Health Benefits.

Proposed “Outside” Market issuers for 2015

- Several issuers submitted filings for both the individual and small group market for the 2015 plan year
- Although health plans sold in the “outside” market are not Qualified Health Plans – they must provide Essential Health Benefits – including the preventive services covered in Session One
- Outside market health benefit plans do not have to use Essential Community Providers – but most do for ease of provider contracting so LHJs should attempt to contract with the issuers shown on the next slide.

Issuers for 2015 Outside market

Issuer	“General” Service Area	Market	New for 2015?
Aetna Life Insurance Company	Statewide	Small Group	No
Asuris Northwest Health	Primarily Eastern Washington	Individual and Small Group	No
Group Health Co-op	Puget Sound and Spokane	Individual and Small Group	No
Group Health Options	Statewide	Individual and Small Group	No
Health Net Health Plan of Oregon	Statewide	Small Group	Yes
Kaiser	Clark and Cowlitz	Individual and Small Group	No
Lifewise Health Plan	Statewide	Individual	No
Moda Health Plan	Statewide	Individual and Small Group	Yes
Premera Blue Cross	Statewide except Clark	Individual and Small Group	No
Regence BlueCross BlueShield of Oregon	Clark	Individual and Small Group	No
Regence Blue Shield	Western Washington except Clark	Individual and Small Group	No

Sub-contracted Networks

- Most health issuers contract directly with providers and facilities to develop their own networks
- Issuers may also enter into contracts with independent networks to deliver some or all of the health services under the issuer's health benefit plan
- If an issuer utilizes a sub-contracted network the issuer is still responsible for meeting all of the OIC's regulatory requirements – including the filing of the provider contracts, networks, timelines for claim payments etc.
- Some issuers “rent” or “subcontract” with an entire network – such as “First Choice Health Plan” or “Multi-Plan-Beech Street” – typically large national plans take this approach

Sub-contracted Networks

- Other issuers may subcontract for specific health services – examples are:
 - Pharmacy Benefit Management Companies (e.g. Express Scripts; CVS Caremark etc.)
 - Complementary medicine services (Chiropractic, massage therapy, acupuncture)
 - Mental Health/Behavioral Health Management Companies (e.g. Magellan Health; Horizon Health etc.)
 - Laboratory management services (e.g. Quest; LabCorp)
- The OIC will review the agreement between the issuer and the network as well as the network and the downstream provider for compliance
- Even though the OIC does not directly regulate the subcontracted network – it requires the issuer to assure that its vendor complies with provider contracting laws

Sub-contracted Networks

- LHJs should pursue contracts with the independent networks to provide access to many more health benefit plans and patients
- Several of the issuers utilize the sub-contracted networks for their QHPs
- If you contact an issuer to inquire about network participation – be sure to ask if they utilize a subcontracted network – and obtain contact information!

OneHealthPort

A private entity formed by a coalition of health issuers, physicians and hospitals to collaborate on utilizing technology to streamline and standardize the sharing of business and clinical information.

Although originally an independent organization its success in collaboration has resulted in its designation as the lead agency for some legislatively mandated initiatives – Uniform Credentialing Services, Administrative Simplification and Utilization Review standardization to name a few.

OneHealthPort Services

OneHealthPort – provides 4 major services to Washington providers and issuers:

1. OneHealthPort SSO (Single Sign on Service) allows providers to access all of the participating health issuer's "provider portals" to check claims, eligibility etc. through just one site
2. OneHealthPort HIE – (Health Information Exchange) allows organizations to share clinical and business information
3. OneHealthPort AdminSimp – a series of work groups made up of providers, hospitals, issuers, & public programs to develop best practices and efficiencies to support administrative simplification
4. OneHealthPort Provider Data Service (PDS) – A statewide system for gathering all the data required by issuers and hospitals utilized for credentialing – Designed to reduce data entry burden for providers and costs for issuers and hospitals. (Mandated by state law)

- Have you ever used OneHealthPort?

OneHealthPort

- If you are new to provider contracting – OneHealthPort is an important place to start especially for credentialing (PDS) as it is utilized by most of the issuers in our state– See their FAQ for more information at:
<http://www.onehealthport.com/content/credentialing-faq>
- Review the services and register at:
<http://www.onehealthport.com/?q=home>

Getting Started

- Review and compile a list of the clinical services provided by your organization – Refer back to the slides from Session 1 for ACA required preventive and screening services
- Identify staff providing the services by training and their license type – staff do not necessarily have to be licensed if supervised by a licensed health care professional
- Review the service areas of the various issuers and determine which companies serve your location – The OIC has a great map that lists the 2014 issuers that serve each county – see:
<http://www.insurance.wa.gov/your-insurance/health-insurance/individuals-families/health-plans-rates/>
- Compile the list of issuers you wish to contact to discuss contracting (see list of contacts)
- Contact the provider relations staff at the issuers either through a letter expressing interest or a phone call of introduction and be persistent! – They may not have experience dealing with an LHJ

Helpful links to Issuer's Provider Contracting Applications

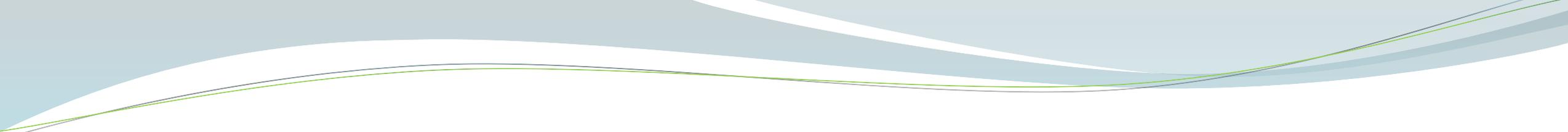
- Aetna
<http://www.aetna.com/health-care-professionals/join-the-aetna-network.htm> |
- Columbia United Providers (new for 2015)
<http://www.cuphealth.com/providers>
- Community Health Plan of Washington
<http://chpw.org/for-providers/welcome/>
- Coordinated Care
<http://www.coordinatedcarehealth.com/for-providers/become-a-provider/>
- First Choice Health Plan (Independent Network)
<https://www.fchn.com/ppo/providers/BecomeProvider.aspx>
- Group Health Cooperative and Group Health Options:
<https://provider.ghc.org/open/>
- Health Alliance Northwest (new for 2015)
Unable to locate provider specific website see: <https://www.healthalliance.org/>

Helpful links to Issuer's Provider Contracting Applications

- Health Net of Oregon
https://www.healthnet.com/portal/provider/content/iwc/provider/unprotected/working_with_HN/content/network_participation_request.action
- Moda Health (new for 2015)
<https://www.modahealth.com/medical/contactus.shtml>
- Molina Health Care of Washington
<http://www.molinahealthcare.com/providers/wa/marketplace/Pages/home.aspx>
- Premera Blue Cross/Lifewise
<https://www.premera.com/wa/provider/reference/join-our-network/>
- Regence BlueShield, Bridgespan, Asuris (All companies under Cambia)-
<http://www.wa.regence.com/provider/contracts-credentialing/index.html>
https://www.asuris.com/web/asuris_provider/home
- United Healthcare (new for 2015)
http://www.uhc.com/physicians/join_our_network.htm

The Negotiation Process – Each Issuer’s process will be different

- Issuers are not required to contract with any willing provider – but they must have an adequate network with a sufficient number and type of providers – especially Essential Community Providers for QHPs
- Most issuers have an on-line application process including credentialing through OneHealthPort
- LHJs may need to be persistent- some issuer’s staff may not be familiar with the LHJ services and personnel
- If the issuer accepts the application – they should send a contract and compensation agreement –
- LHJs will most likely be asked to sign a non-disclosure agreement prior to the receipt of proposed compensation amounts

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- Have you received a contract from an issuer that did not include the compensation agreement?

Reviewing the Contract terms

- If the LHJ's application is accepted – the issuer should send a contract for review and provide information on where to access the provider manual (usually on-line)
- The contract template should be the “approved” form that was reviewed and accepted by the OIC
- Review the contract carefully before signing especially:
 - LHJ responsibility for Administrative Requirements (may be in provider manual):
 - Payment terms
 - Utilization review
 - Quality assessment and improvement programs – Data submission may be required
 - Credentialing
 - Grievance procedures
 - Data reporting requirements
 - Confidentiality requirements and
 - Any applicable federal or state requirements

Reviewing the Contract terms

- Audit and Medical Record Review requirements – must be mutual
- Claim payment requirements & timelines;
 - 95% of monthly clean claims are paid within 30 days of receipt, and
 - 95% of all claims are paid or denied within 60 days.
 - 1% Interest per month must be paid on all non-denied and unpaid clean claims 61 days or older when carrier does not meet standards.
- Notice of Change to Compensation must be received at least 60 days' before effective and provider may terminate contract with notice of change is unacceptable – must be accepted in writing
- Contract Termination notice time period must be at least 60 days for termination without cause

Reviewing the Contract Terms

- The contract may not modify benefits, terms, or conditions contained in the health benefit plan. In the event of a conflict between the contract and the health plan, the benefits, terms, and conditions of the health benefit plan shall govern
- Pre-authorization processes must be defined and payment may not be denied for a pre-authorized service unless the pre-authorization was withdrawn in writing **before** the services were rendered (RCW 48.43.525)
- Provider Grievance and Appeal Process needs to be included in contract
- Every Contract shall contain procedures for the fair resolution of disputes arising out of the contract.
 - Not less than 30 days to file a dispute.
 - All likely disputes need to be identified (billing, eligibility etc.)
 - Process may not unfairly advantage the issuer
 - Cannot exclude judicial remedies.
 - Cannot require binding Arbitration.
 - Billing disputes should be resolved within 60 days' time

Reviewing the Contract Terms

- The agreement must contain the mandatory “hold harmless” provision and providers may not bill patients for covered services (except for cost sharing amounts) Even if the issuer does not pay the claim
- Required “hold harmless” language set forth in WAC 284-43-320 at:
<http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-320>
- Overpayment/Underpayment recovery rights
 - Both parties must have the same time period to request overpayment refund (issuers) or additional payment (providers) – typical time limit for both is 24 months but time frame may be shortened as long as it is the same period for both parties
- May require compliance with administrative procedures manual – but manual may not be incorporated by reference into and made a part of the contract

Reviewing the Contract Terms - a special note about public disclosure

- Non- disclosure clause may state that terms and conditions – especially compensation amounts may not be disclosed to 3rd parties without written permission creating potential problem with public disclosure laws
- Many public entities are subject to the same constraints – and so the following procedures are used by the OIC
 - If a request for the contract is received by your public disclosure officer – immediately notify the issuer in writing of the request and request permission to release; and
 - Inform them that under the public disclosure law that the LHJ must release the contract unless the issuer goes to a court of competent jurisdiction to block the release
 - Include a copy of the request in the written notice to the issuer
 - Make sure you comply with the timelines for response – including the initial acknowledgement of receipt of the request

Reviewing the Contract Terms - a special note about mal-practice insurance

- Most issuers require a minimum amount of medical malpractice or professional liability insurance coverage
- As many counties and other public agencies are “self-insured” it will be necessary to provide special information about your county’s risk pool or other insurance mechanism
- Obtain information including official documentation about the nature of the risk pool or self-insured arrangements and be prepared to submit the documentation as part of the application process
- Make sure that your county’s Risk Manager (if you have one) is aware of the LHJs intent to participate in an issuer’s network – this should not create any additional “risk” for the county

The Provider Manual

- All issuers must make provider administrative procedures available for provider review at time of contracting
- Most provider manuals are now on-line and contain detailed information
- Providers should review the manual carefully to understand the issuer's requirements and expectations
- The Provider Manual is not filed with or reviewed by the OIC
- Issuers are required to provide notices of changes to the provider manuals and these are typically through monthly or quarterly newsletters as well as notices on the issuer's website
- Issuers may not make changes to their administrative procedures that result in a change to compensation – These changes must be in the contract – watch out for “penalty” fees

The Provider Manual

- The provider manual will provide information on claims and data submission
- Issuer may require submission of encounter data and customer satisfaction survey information – Review this information carefully
- Prior authorization and utilization review procedures are typically included in the manual
- As LHJs won't be engaged in complex medical care the administrative burden should be less than full scope outpatient multi-specialty clinics

The Compensation Exhibit

- The compensation exhibit sets forth the reimbursement methodology and may be as simple as a schedule of fees or a discount off of a standard fee schedule; or
- As complex as a risk sharing arrangement that bases reimbursement on health care outcomes
- The LHJs may see fee arrangements that are fairly simple, but must be prepared to deal with more complex Relative Value Unit (RVU) systems with a conversion factor
- Most commercial plans will try and negotiate fees as a percentage of Medicaid or Medicare rates – often expressed as a percentage – make sure you understand which version the issuer is using
- Most issuers are trying to move away from fee for service - however,

Compensation Exhibit

- Review the Exhibit carefully to be aware of any automatic updates or changes, typically tied to actions by the Centers for Medicaid and Medicare Services (CMS) when they adjust Medicare reimbursement rates
- It is unlikely that LHJs will see financial performance incentives built into the Compensation Exhibit (at least initially) due to the limited nature of the services provided – however, you may be asked to submit data to support quality initiatives -
- In the future if LHJ forms a partnership with other local providers or facilities – to provide some of the preventive and screening services, quality incentives may be built into the compensation
- LHJs may wish to reach out to newly formed Integrated Delivery systems to provide Essential Health Services
- The Compensation exhibit most likely will differentiate between commercial products, Medicaid managed care plans and perhaps Medicare Advantage plans – if your contract is for more than one type of product, make sure it is reflected in the compensation exhibit

Compensation Exhibit

- The Compensation Exhibit may contain different rate or fee schedules for different networks offered by an issuer – make sure it is clear and corresponds to the networks the LHJ has contracted to serve
- The Compensation Exhibit is filed with the OIC – but the OIC does not regulate the provider reimbursement rates
- The OIC uses the compensation amounts to assure that benefit design and network does not discriminate against patients based on health status
- While the base provider contract filing is available for public inspection – the compensation exhibit is exempt from disclosure under RCW 48.43.730

The Compensation Agreement – A special word about Vaccines

- In 2010 the legislature created the Washington Vaccine Association (WVA) to help the state continue its universal purchase of vaccines for children under the age 19
- Information about the WVA is at:
<http://www.wavaccine.org/wavaccine.nsf/pages/home.html>
- Most health issuers – especially those in the commercial market should know about this system – Issuers new to the commercial market may be unaware that they must pay for the vaccine
- LHJs administering vaccines must be reimbursed by commercial issuers
- The compensation exhibit is a good place to address reimbursement for both the office visit and the vaccine

Amending the Provider Contract

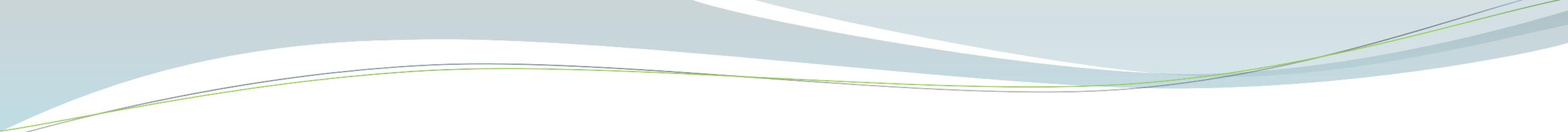
- In 2013 the Legislature passed legislation requested by the Washington State Medical Association – found in Ch. 48.39 RCW see:
<http://apps.leg.wa.gov/rcw/default.aspx?cite=48.39>
- The Findings of the Act RCW 48.39.003 states:
“The legislature finds that Washington state is a provider friendly state within which to practice medicine. As part of health care reform, Washington state endeavors to establish and operate a state-based health benefits exchange wherein insurance products will be offered for sale and add potentially three hundred thousand patients to commercial insurance, and to expand access to Medicaid for potentially three hundred thousand new enrollees. Such a successful and new insurance market in Washington state will require the willing participation of all categories of health care providers. The legislature further finds that principles of fair contracting apply to all contracts between health care providers and health insurance carriers offering insurance within Washington state and that fair dealings and transparency in expectations should be present in interactions between all third-party payors and health care providers.”

Amending the Provider Contract

- This legislation passed because some issuers were sending out unilateral contract amendments in early 2013 and requiring providers to accept Medicaid rates for their commercial products
- The legislation requires that all amendments be in writing and subject to acceptance by the provider
- The issuer may not cancel the underlying provider contract if the provider rejects the amendment (RCW 48.39.010)

Amending the Provider Contract

- Provider contracts and amendments must be filed with the OIC for approval 30 days' before use
- If the provider wishes to negotiate changes to the provider contract – those changes must be made through a contract amendment and filed with the OIC
- Large hospitals and multi-specialty clinics may negotiate changes but it is unlikely that LHJs will be successful in negotiating amendments to the contract
- A contract amendment must clearly state which section of the base contract is being deleted, replaced or amended – and must have a signature block for acceptance by all parties

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- Have you successfully amended an issuer contract?

Questions?

Questions may also be sent to Carri Comer at carri.comer@doh.wa.gov or (360) 236-4004

Carri Comer

Washington State Department of Health

Strategic Operation Lead for Health Systems Transformation and Innovation

Where to go for Help

- Issuer Provider Relations

Most issuers will assign a provider representative for you to contact. You can also call the health issuer's customer service unit and they frequently have dedicated lines for providers

- Office of Insurance Commissioner

The OIC's Consumer Advocacy hotline: 1-800-562-6900 or file an "on-line complaint" at:
<http://www.insurance.wa.gov/complaints-and-fraud/file-a-complaint/>

Even if the OIC does not have jurisdiction – their consumer advocates can often provide helpful advice

- Health Care Authority (Medicaid / Apple Health)

1-800-562-3022

<http://www.hca.wa.gov/medicaid/provider/Pages/index.aspx>

- OneHealthPort – use their "Contact Us Form" on the website below

- <http://www.onehealthport.com/content/contact-us>

Helpful Links

- Insurance Commissioner's Web Site:
www.insurance.wa.gov
- Health Plan Finder – Washington's Health Benefit Exchange
<http://www.wahbexchange.org/>
- Topical Fact Sheets dealing with ACA issues from Federal Government
<http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/index.html>
- Glossary of Terms under the ACA"
<https://www.healthcare.gov/glossary/>
- HRSA Guidelines for Women's Preventive Services Guidelines:
<http://www.hrsa.gov/womensguidelines/>