Health Plans Contracting Handbook: A Guide for Payers and Providers

Eighth Edition

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—from a declaration of the American Bar Association

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Preface

The Health Plans Contracting Handbook: A Guide for Payers and Providers, published by the American Health Law Association, is the 8th edition of a work that has served as a resource for practitioners for two decades. It has become a classic and one of the essential tools of the health law practitioner's library.

The intent behind the *Health Plans Contracting Handbook* is to provide advice on addressing the issues that arise in managed care network relationships. These contracts often endure for years at a time and must document increasingly dynamic relationships between the parties, including changes in products, governing laws, and medical and administrative best practices for both payers and providers alike. As with prior editions, this book attempts a balanced approach and practical focus, rather than exhaustive reporting on the state of the law. We aim to provide sample clauses to assist you in thinking about and drafting appropriate language; many of which are based on real examples. Throughout the book, the authors have provided cites to cases or state statutes to help you begin research as needed, but an exhaustive description of the state of the law, including the variations among jurisdictions, is beyond the scope of this publication.

As previous editions have done, the 8th edition examines emerging themes and issues in the managed care contracting space. We continue to see large health systems launching as independent payers or through integrated delivery models and have incorporated issues arising with this additional layer of contracting throughout the book. The chapters reflect the increasing focus on value-based payments and the financial and operational considerations for arrangements that incorporate them. This edition includes three new chapters reflecting additional changes in the field: the uses and ownership of data, direct-to-employer contracting, and considerations when the provider is out-of-network. Finally, the chapters, particularly the chapters dealing with Medicare and Medicaid, consider the effects of increased managed care penetration into populations that have traditionally been carved out of managed care, such as individuals with chronic conditions and more complex populations, including individuals with intellectual and developmental disabilities and foster children.

This volume was started before the COVID pandemic and before we had any understanding of the monumental changes that were about to affect how we conduct meetings, operate, and even greet each other. The first drafts were due at the end of March 2020, just as stay-at-home orders were going into effect. It is a tribute to the authors that none abandoned the project, even as their workloads increased during this unprecedented time. Every chapter was informed by and improved as a result of the pandemic. We are grateful to the authors and their incredible commitment to this edition.

This edition would not have been possible, and certainly would not have been timely, without the assistance of Kara Kinney Cartwright, whose continuing and expert guidance kept us all on track.

We mourn the loss of Kathrin (Kathy) Kudner, our well-respected colleague and a long-standing author of the chapter on Medicaid. We extend our sincere thanks for her firm, Dykema Gossett, and specifically her colleague, Gerald (Jerry) Aben, for stepping in and completing her excellent work.

Since we began updating this 8th edition, we have seen the onset of the COVID pandemic, the rise of telehealth, the increased use of online scheduling, remote monitoring, and many other changes that will be interpreted through the lens of thousands of managed care contracts. We hope that this volume will provide reliable guidance to health care practitioners as they navigate the changes ahead.

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November 2020

About the Editors

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Payer Programs and Policies: Utilization Management and Quality Assurance

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A payer's utilization management and quality assurance programs are fundamental to the working relationship between payer and provider, but they are often overlooked as part of the contract negotiating process. Providers tend to focus on negotiating reimbursement rates, but payer utilization management and quality assurance programs can have a significant impact on reimbursement. Utilization management (UM) is a general term that describes the process by which a payer decides whether health care services are appropriate for coverage under an enrollee's plan. Quality assurance (QA) refers generally to procedures designed to promote the quality of health care services received by enrollees. Because there is considerable overlap between UM and QA activities, both functionally and because QA entails evaluating all programs including UM, these two programs often are discussed together. The purpose of this chapter is to provide an overview of the key considerations related to UM and QA programs under managed care contracts, to identify the competing interests of payers and providers with respect to such considerations, and to offer contract language designed to describe alternative approaches to defining the parties' respective rights with regard to these programs.

6.1 Payer Programs and Policies

When defining the relationship between a provider and a payer, the rights and obligations described in the contract itself often are only the "tip of the iceberg." Typically, the contract contains the most basic elements of the relationship between a payer and a provider and relegates the operational details to the payer's set of policies and procedures or provider manual (referred to in this chapter collectively as the Manual). This certainly is true with respect to a payer's UM and QA policies and procedures, the details of which are virtually always captured in the Manual.

The payer almost always retains the unilateral right to modify the Manual at will.[1] A typical contract will require the provider to "abide by and comply with such policies and procedures as the payer shall implement from time to time."

From the payer's perspective, maintaining maximum flexibility is essential to (i) accommodating the changing needs of the marketplace for its enrollees and plan sponsors; (ii) administering a large network with numerous types of providers, including new product and quality initiative development; (iii) implementing changes based on the payer's automated internal systems; and (iv) meeting the needs of other payers accessing the network, such as self-insured employer groups.

[1] Refer to **Chapter 5*, Policy and Procedure Amendments***, for further discussion.

On the other hand, the provider needs to be able to review the Manual and understand the effect on the provider's operations and what is required to comply. In addition, the provider will want, to the maximum extent possible, to restrict changes made to those policies (or at least limit their application to the provider) while the contract is in effect. The provider will want to avoid changes that undermine the benefit of its negotiated bargain, as well as changes that interrupt the provider's practice or are administratively burdensome because of the time, expense, or staff retraining required to comply.

In conjunction with attempting to negotiate restrictions on a payer's ability to amend its Manual, the provider should be aware of any state law requirements for advance notice of changes to the Manual. For example, New Hampshire law requires that a payer make its most current Manual available to providers "prior to the execution" of the contract.[2] Colorado requires a payer to give 90 days' advance notice of "material changes" to a contract and defines "material changes" to include changes to administrative procedures. Colorado providers have 15 days to object to the change, and if the parties are unable to resolve the objection, the provider can terminate upon 60 days' notice.[3] Even if a provider operates in a state where state law requirements do not require advance notice, providers can learn important lessons from those states that do and request similar language in their respective payer contracts.

Sample 6.1-A: Payer Programs (Payer Friendly)

Provider shall abide by and comply with such policies and procedures as Payer shall implement from time to time. Payer may amend its policies and procedures from time to time in its discretion, with notice to Provider.

Sample 6.1-B: Payer Programs (Provider Friendly)

Provider shall abide by and comply with Payer's policies and procedures as set forth in the Manual; provided, however, that if any provision in the Manual is inconsistent with any provision in this Agreement, the applicable provision of this Agreement shall prevail. Payer represents and warrants that, as part of the process of negotiating this Agreement, Payer has given Provider the Payer's most current Manual, including all updates. Provider acknowledges that Payer may amend the Manual from time to time in accordance with this Section. Except for changes required by applicable law, Payer shall limit Manual changes to no more than once per calendar quarter. Before the effective date of any amendment to the Manual, Payer shall give Provider actual notice of the change by mailing a printed update, postage prepaid to the [*Specific Provider Person responsible for reviewing Manual changes*] or making the updated Manual provisions available electronically with a summary describing the changes and links to the specific location of each change in the Manual. Payer shall give Provider 90 days' advance notice of any Material Change to the Manual. The change shall not become effective during the notice period. For purposes of this Section, a Material Change is a change from the Manual provisions in effect on the Effective Date that requires substantial Provider time or expense to implement. If Provider determines that a change is a Material Change, Provider shall have 15 days to raise any objections to the change. If Provider objects to the change and Provider and Payer are unable to resolve the matter, either party shall be entitled to terminate upon 60 days' notice.

[2] N.H. Rev. Stat. Ann. §420-J:8 VIII(b).
[3] Colo. Rev. Stat. § 25-37-104.

6.2 What Is Utilization Management?

Utilization management is a central element of managed care and thus is a key feature of any managed care contract. According to URAC (formerly known as the Utilization Review Accreditation Commission), an organization that publishes standards for health care organizations and accredits them, UM is the independent, unbiased evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the health benefits plan.[4] UM can also encompass the payer's more active involvement in the care of its enrollees, including assisting with the planning of a course of treatment.

UM can take place at many points in the health care delivery cycle, including preauthorization review, concurrent review, or retrospective review. A payer's UM program is designed to evaluate health care on the basis of appropriateness, necessity, and quality of the service. As payers have gained more experience with UM, they have increasingly incorporated case management, drug utilization management, or disease management programs into their UM programs.

A payer's UM and QA programs usually work hand-in-hand. The QA process will typically include elements such as physician profiling, measuring quality performance standards,[5] clinical practice guidelines, and credentialing. Although the payer usually controls its own UM program, the provider maintains a strong interest in this aspect of a managed care arrangement for several reasons:

- the provider may opt to partner with the payer to perform some UM functions;
- the payer's UM program will affect the provider's operations and administrative costs;
- the payer's UM program can significantly affect the provider's payment;
- any payer delegation of the UM function to a third-party UM company could affect the manner in which the function is performed; and
- the provider may decide to advocate on behalf of its patients for a specific service or course of treatment.

6.2.1 Utilization Management Programs

Problem: The contract will obligate the provider to comply with the payer's UM program. Oftentimes, there is a lack of transparency regarding the components of the UM program. How many claims will be reviewed during a quarter? What will be the credentials of the payer's UM reviewers—nurse reviewer or physician reviewer? In the case of a physician reviewer, will the physician be a specialist or general practice physician? What UM policies will apply—the payer's internal policies, Centers for Medicare & Medicaid Services (CMS) policies, or the policies of national review companies such as InterQual or Milliman or a delegated third-party UM company? In order for a UM program to work smoothly, payer

[4] Details regarding URAC's Health Utilization Management Accreditation standards are *available at* https://www.urac.org/programs/health-utilization-management-accreditation.

[5] For a description of Quality Performance Standards for participants in the Shared Savings Program of the Centers for Medicare & Medicaid Services (CMS), *see* 42 C.F.R. Part 425, Subpart F—Quality Performance Standards and Reporting; *see also* Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice, 76 Fed. Reg. 19528, 19571–91 (Apr. 7, 2011).

and provider each need to be able to perform a series of detailed and time-sensitive tasks and understand the policies and process that will apply to the parties.

Solution: Careful review of the payer's UM program is crucial for both parties. If possible, the entire UM program should be reviewed prior to execution of the contract. Providers want to give consideration to some components that affect the provider such as the guidelines for services the provider frequently renders. Providers need to ask questions about how the UM program will work in real practice. Questions ranging from the structure of the program to the qualifications of reviewers should be addressed.

- Does the payer outsource its UM program to a third-party UM company?
- Is that third-party UM company familiar with state and CMS requirements for the managed care program?
- What are the qualifications for reviewers?
- If the provider is a children's specialty hospital frequently providing liver transplants to children, does the provider want a pediatric specialist reviewing the medical necessity of transplant services?

If not too lengthy, the UM program could be attached as an exhibit; indeed, some states require this.[6] In recognition of the payer's need to amend its UM program periodically, including incorporating changes that can reduce the provider's administrative burden, the parties can agree on a process for review and approval of changes to the UM program that will have a material effect on the provider's operations.

Providers can also consider developing their own UM addendums for inclusion in the contract with the payer. These addendums can address a number of the questions raised above. For example, if a provider wants a physician to complete its UM reviews or wants the reviews to occur on provider premises, then this requirement should be set forth in the addendum. The addendum is something that should be prepared in advance of contract negotiations with the payer. It contains details about how the provider wants the UM relationship to work between payer and provider. It serves as an important tool to help identify and raise potential issues and concerns during the contract negotiating process.

Careful review of the UM program prior to execution of the contract will benefit both the payer and the provider. The parties will know what is expected and can ensure their operations will facilitate the UM program.

Sample 6.2.1-A: Utilization Management Program (Payer Friendly)

As a condition for payment for Covered Services, Provider agrees to participate in and comply with the UM Program and QA Program (UM/QA Program) utilized by Payer to promote the efficient use of resources. Provider shall comply with and, subject to Provider's right to appeal as provided in the UM/QA Program, be bound by such UM/QA Program. Failure by Provider to comply with the requirements of this paragraph will be deemed to be a material breach of this Agreement.

[6] *See, e.g.*, Va. Code § 38.2-3407.15(B)(9).

Sample 6.2.1-B: Utilization Management Program (Provider Friendly)

Provider agrees to participate in and cooperate with the UM Program and QA Program (UM/QA Program) utilized by Payer, subject to Provider's right to appeal any adverse decisions. Provider has been given Payer's most up-to-date Manual and applicable policies and procedures related to the UM review process. Payer and Provider agree to meet and discuss any changes to the UM provisions in the Manual that may materially affect Provider's obligations. If any provision in the Manual is inconsistent with any provision in the Agreement, the applicable provision of this Agreement shall prevail.

Sample 6.2.1-C: Utilization Management Program (Provider-Friendly Addendum Setting Forth Provider's UM Review Policy)

Provider agrees to participate in and cooperate with the UM Program and QA Program (UM/QA Program) utilized by Payer, subject to Provider's right to appeal any adverse decisions. Provider has been given Payer's most up-to-date Manual and applicable policies and procedures related to the UM review process. Payer and Provider agree to meet and discuss any changes to the UM provisions in the Manual that may materially affect Provider's obligations. Provider shall abide by and comply with Payer's policies and procedures as set forth in the Manual; provided, however, that if any provision in the Manual is inconsistent with any provision in this Agreement or Addendum, the applicable provision of this Agreement shall prevail.

6.2.2 Types of Utilization Review

Utilization review (UR) is often referred to interchangeably with UM in the health care industry, but it is a subset of UM. Whereas UM entails the payer's active participation in planning and managing an enrollee's course of care, UR tends to be passive, involving the payer's review of the treatment proposed or provided to an enrollee in order to decide whether the treatment is a covered service under the enrollee's plan.

There are generally three types of UR: prospective, concurrent, and retrospective. Prospective review involves preauthorization before the initiation of treatment to determine medical necessity. Concurrent review is performed during the course of treatment and involves monitoring to determine whether the care continues to be appropriate and necessary. Finally, retrospective review is performed after the treatment has been completed.

6.2.2.1 Prospective Review and Preauthorization

Payers have traditionally required prior authorization or preadmission certification before a provider delivers inpatient or certain outpatient services to an enrollee. The prospective review conducted for such certification generally involves confirmation that (i) the patient is an enrollee, (ii) the contemplated services are covered by the enrollee's health plan, (iii) the level or type of treatment sought (or both) is consistent with applicable UM program policies, and (iv) the provider is approved for the provision of such services to enrollees. Prospective review often gives rise to four related issues.

The first issue concerns the process the provider must follow for verifying eligibility of the enrollee, including when notice must be given to the payer. Every payer has its own system or procedure for this verification. Increasingly, payers are offering, and many providers are insisting upon, real-time confirmation of eligibility, benefit design, and payment, including the enrollee's payment obligations, on a 24-hour per day, 7-day per week basis.

The second area concerns how quickly a payer is required to provide certification of medical necessity and what information will be available to the provider at the time it seeks certification from the payer. Providers are requesting information about which benefit plan covers the enrollee; relevant specifics of the benefit design; the amount of the enrollee's financial obligation, including whether a deductible has been met; any coverage limits; and whether the enrollee is covered through a self-insured group.

The third issue concerns whether the provider may rely on a payer's eligibility verification to bind the payer to pay the eventual claim. This is a separate question from whether the provider may rely on the payer's prior authorization that the specific services will be covered.

The fourth issue concerns the extent to which a payer may use subsequently available information to overturn or adjust its initial authorization.

Compliance with preauthorization requirements can be overlooked in the contract negotiation process, which can lead to devastating consequences. If a provider misses a preauthorization time frame, the payer can deny the claim. It does not matter that the services were medically necessary. It does not matter that the patient benefited from care. Lack of timely preauthorization allows the payer to deny a claim essentially on a technicality.

Problem 1: There should be a system for verifying enrollee eligibility that can be relied on by the parties to the contract.

Solution 1: Payers have several ways to identify their eligible enrollees: (i) identification cards, (ii) enrollee lists given to providers, (iii) telephone verification of eligibility, (iv) online search capability, or (v) a combination of these methods. The provider should carefully review the specific procedure in the contract for enrollee eligibility verification, and the payer should include a system summary as a contract exhibit, if possible.

Sample 6.2.2.1-A: Enrollee I.D. Card (Payer Friendly)

Payer, as part of its Enrollee identification process, shall make available to Provider electronic eligibility information regarding all current Enrollees. Provider shall receive regular updates regarding all current Enrollees who have selected or have been assigned to Provider. Payer shall provide each Enrollee with an identification card, properly identifying Payer, the Enrollee's name, eligibility dates and identification number and information on where to submit required notices to provide Covered Services to an Enrollee. Provider agrees that all reasonable efforts shall be made to verify the eligibility and ~~status of Enrol~~lees. The verification process shall include, but not be limited to, checking Enrollee identification cards and Enrollee listings, or, if necessary, contacting Payer. Provider may call Payer's eligibility service center to verify eligibility on normal business days from 8:00 a.m. until 5:00 p.m.

Sample 6.2.2.1-B: Enrollee I.D. Card (Provider Friendly)
Payer shall provide identification cards to all Enrollees. Payer shall assure that information on the identification cards clearly identifies the Enrollee's eligibility date, Enrollee's identification number, the applicable telephone number where Provider may reach a UM representative, the applicable claims address and a telephone number where Provider can verify eligibility, the product covering the Enrollee, the entity responsible for payment, and certification information in order to provide Covered Services to an Enrollee. The parties understand that an Enrollee must present his or her identification card to Provider upon a request for Covered Services.

Problem 2: If the UM program allows for telephonic or electronic preauthorization, the contract should specify time frames for the provider to notify the payer and what information the provider will receive in return.[7]

Solution 2: The contract or a preauthorization exhibit should set out the time periods within which the provider must notify the payer and the payer must respond to preauthorization requests. The contract or Manual should also describe the procedure for preauthorization for each type of service, if there are different requirements. For example, telephonic or electronic preauthorization may be sufficient for routine, noninvasive care, whereas an invasive procedure may require a second medical opinion. The parties may also wish to exempt certain services from the preauthorization requirement. In such a case, it is preferred that the exempt services be listed in the contract instead of in the Manual, as the Manual can be unilaterally amended, as noted above.

Problem 3: Many payers that provide a system for telephonic or online verification of eligibility make that system available 24 hours a day, 7 days a week. This real-time availability causes payers to require real-time notification for preauthorization purposes. Generally, payers want notification within 24 hours of the admission or the next business day. Additionally, if the payer's verification system is available only on a more limited basis, providers may need to provide services without having obtained prior verification.

Problem 3 illustrates the need for providers to evaluate their internal operations related to the preauthorization process. Is notification within 24 hours reasonable from an operations standpoint? Does state law allow a longer period for notification? Should the provider ask for a longer period of time to make the preauthorization request? For example, a patient presents through the emergency department with a gunshot wound. Should the payer be allowed to deny all payment for inpatient services because the provider waited until day 3 of the subsequent inpatient admission to request authorization? If the payer and provider cannot agree on a longer notice period, consider specifying circumstances when the notice period can be waived or extended for good cause or a lesser consequence.

Problem 3 also demonstrates the need for the parties to be familiar with any applicable state law requirements relating to UR. Arizona law requires a payer that requires prior autho-

[7] As part of its internal process, the provider needs to develop a system that tracks or records any telephonic or electronic preauthorization in the event the payer later takes the position that it did not receive preauthorization. For example, if the provider sends a preauthorization to the payer electronically, the provider needs to document delivery confirmation to the payer in the patient's medical or case management records.

rization to "provide twenty-four hour access by telephone or facsimile for enrollees and providers to request prior authorization for medically necessary care."[8]

Solution 3: The contract should address the provider's responsibility for obtaining prior verification at times when the system is not available. If the proposed preauthorization notification time period will not work from an operations standpoint, then the provider needs to negotiate a longer time period. The contract should also address who bears the financial responsibility for services provided without prior verification during those times when the system is not available or when prior verification is not requested, including when prior verification is prohibited by law. Rather than face denial of payment, the provider may seek an alternative process, such as retrospective review to ensure payment for services that would have been approved as medically necessary if verification had been timely obtained. This should be stated in the contract.

Problem 4: On some occasions, the payer may reverse an initial verification of eligibility when it determines that the prospective enrollee is not truly eligible for the benefits sought.

Solution 4: The provider may negotiate for the right to rely on identification cards, enrollee lists, and online or telephone authorizations provided by the payer. The provider may also seek to incorporate a provision guaranteeing payment for services rendered in reliance on the payer's identification and authorization systems unless the provider has actual knowledge of ineligibility. The payer may wish to expressly state in the contract that verification of eligibility does not guarantee the payment of benefits. *See also* **Section 6.2.2.3, Retroactive Disenrollment**, below. In light of the challenges with enrollment, premium payment, and the "grace period" during this period of uncertainty caused by the launch of health insurance exchanges, payers are reluctant to assume the risk arising from verifying coverage for an individual who may or may not turn out to be an enrollee.

Problem 5: Upon review of a claim, the payer may deny payment for services that were preauthorized because the payer believes that the treatment provided differs from the treatment authorized or that the enrollee's actual condition differed from the condition described in the request for prior authorization.

Solution 5: Sometimes a patient's initial diagnosis changes during the course of evaluation or it becomes medically necessary to alter a preauthorized course of treatment. The provider may negotiate for the right to a binding determination of coverage so long as the provider gave the payer information that was accurate to the best of its knowledge at the time it requested authorization. The payer may reserve the right to reevaluate the medical necessity of services rendered during the course of treatment or after services are delivered. Sometimes it is possible to reach a compromise that limits the payer to disallowing coverage for certain limited reasons expressly stated in the contract.

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[8] Ariz. Rev. Stat. § 20-2803(E).

Again, state law may affect the permissible terms of the contract. For example, Illinois law restricts a payer to rely "solely on the medical information available to the attending physician or ordering provider at the time the health care services were provided."[9]

Sample 6.2.2.1-C: Enrollee Verification and Preauthorization (Payer Friendly)

Except in an emergency, prior to providing any Covered Services to a person who is purportedly an Enrollee, Provider will follow Payer's verification and authorization procedures to verify that such person is an Enrollee and that the services to be provided constitute Covered Services.

Sample 6.2.2.1-D: Enrollee Verification and Preauthorization (Provider Friendly)

Payer shall furnish Provider with a system for identifying all Enrollees as described in Exhibit ___. Except for emergency care, Provider shall confirm Enrollee status and secure Payer preauthorization before rendering services. Upon a request for Enrollee treatment, Provider shall contact Payer by telephone to confirm Enrollee status. Payer shall confirm Enrollee's eligibility for benefits and issue a certification decision within ___ hours of receiving Provider's request. Upon verification by the Payer of the Enrollee's membership status, Payer shall give to Provider a preauthorization code indicating approval upon which Provider may conclusively rely for the delivery of the preauthorized services to the Enrollee. If Provider obtains such verification, Payer shall not retroactively deny payment unless: (i) the services are not provided as described in the request for preauthorization; (ii) the Enrollee's condition materially differs from the condition described at the time of preauthorization; or (iii) the services are not found to be Medically Necessary.

In recent years, some payers have been replacing their prior authorization requirements with a requirement of prior notification. The goal is to replace the process of reviewing and making an advance conditional coverage determination with an opportunity to identify enrollees embarking on a complex or costly course of treatment and to engage them in one or more active forms of medical management, as described below.

6.2.2.2 Loss of Enrollee Eligibility During Treatment

An enrollee may lose eligibility for benefits while the enrollee is an inpatient or in the midst of a course of treatment. This can happen because the enrollee exhausts his or her benefits[10] or because the enrollee's coverage ends, including due to nonpayment of premiums.

Problem: Who is responsible for the cost of ongoing treatment in the event of loss of eligibility? From the provider's perspective, it may not be fair to penalize the provider

[9] 215 Ill. Comp. Stat. Ann. § 134/85(e)(3); *see also* Ariz. Rev. Stat. § 20-2803(F) (stating payer "that gives prior authorization for specific care by a provider shall not rescind or modify the authorization after the provider renders the authorized care in good faith and pursuant to the authorization").

[10] See the limits on a payer's ability to offer plans with lifetime or annual benefit caps at Section 2711 of the Public Health Service Act, as added by Section 1001(2)–(4) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148.