Contracting for Commercial & Medicare Success

Forvis Mazars With Co-Sponsor: Achieve Revenue Management

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Introductions

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Prevalent Types of FQHC Contracts

Common Plan Types

- Medicare (including Medicare Advantage)
- Medicaid (including MCOs)
- PPOs
- Fee-for-service arrangements
- Value-based care arrangements
- Other
- Is this changing?
- What should we consider?

HRSA Guidance

Health Center Compliance Manual

- The health center must make every reasonable effort to enter into contractual or other arrangements to collect reimbursement of its costs with the appropriate agency(s) of the State which administers or supervises the administration of:
  - A State Medicaid plan
  - The Children's Health Insurance Program (CHIP)
- The health center must make and continue to make every reasonable effort to collect appropriate reimbursement for its costs on the basis of the full amount of fees and payments for health center services without application of any discount when providing health services to persons who are entitled to:
  - Medicare coverage
  - Medicaid coverage under a State plan
  - Assistance for medical expenses under any other public assistance program (for example, CHIP), grant program, or private health insurance or benefit program.

https://bphc.hrsa.gov/compliance/compliance-manual/chapter16

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Health Center Compliance Manual

- The health center participates in Medicaid, CHIP, Medicare, and, as appropriate, other public or private assistance programs or health insurance
- The health center determines whether to participate in a specific insurance plan based on its patient population and the costs and benefits of such participation
- Health center patients who are eligible for sliding fee discounts and have third-party coverage are charged no more for any out-of-pocket costs than they would have paid under the applicable SFDS discount pay class. Such discounts are subject to potential legal and contractual restrictions.

https://bphc.hrsa.gov/compliance/compliance-manual/chapter16

https://bphc.hrsa.gov/compliance/compliance-manual/chapter9

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Health Center Compliance Manual

- The health center must prepare a schedule of fees for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation
- The health center has a fee schedule for services that are within the HRSA-approved scope of project and are typically billed for in the local health care market
- The health center uses data on locally prevailing rates and actual health center costs to develop and update its fee schedule

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Key Financial and Operational Consideration

Why should we care about the MPFS?

- Many commercial contracts tie reimbursement to the Medicare Physician Fee Schedule
- For example: “Reimbursement will be paid at an amount which equals 115% of the Medicare fee schedule as adopted by the Health Plan…the fee schedule shall be updated from time to time as determined by the Health Plan.”
- What’s been happening with the MPFS?

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Five Years of MPFS

Year	Conversion Factor	% Change
2019	$36.0391	0.11
2020	$36.0896	0.14
2021	$34.8931	-3.3
2022	$34.6062	-0.80
2023	$33.8872	-2

https://www.ama-assn.org/system/files/2021-01/cf-history.pdf

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Does Our Fee Schedule Matter?

- Yes and no…
- Charges may be used to support reimbursement and uncompensated care
- Very few (if any) payers reimburse based on charge amount
- Many arrangements based on “lesser of” provisions
- For example, “Reimbursement will be paid at the lesser of the Health Plan’s established fee schedule or the Provider’s billed charge amount.”

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- Example for Discussion

CPT	Description	Clinic Fee	BCBS	Medicare FFS	Aetna
17000	Destruction benign lesion	$90.00	$82.00	$66.77	$71.31
36415	Venipuncture	$5.00	$4.31	$3.00	$6.92
99213	Office visit	$115.00	$92.43	$76.15	$85.21
99497	Advanced care planning	$75.00	$43.21	$86.98	$0.00

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Commercial or Private Plans

- Often viewed as a “physician group”
- Reimbursement typically tied to established fee schedule amounts
- Ability to negotiate
- Plans are not required to offer FQHCs cost based reimbursement
- Plans may require health center to attempt to collect patient responsibility

Commercial or Private Plans ~ Service Delivery

- Contract should:
  - Describe services covered along with any limitations or exclusions
  - Address medical necessity or coverage policies
  - Outline prior authorization policies
  - Define requirements related to patient access and emergency care
  - Identify utilization review (UR) and quality review structures
  - Disclose referral and pharmacy requirements

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Commercial or Private Plans ~ Credentialing

- Contract should:
  - Describe credentialing procedures
  - Outline which providers are separately credentialed
  - Address whether participation status is retroactive
  - Define turn-around times
  - Include recredentialing requirements (if any)

Commercial or Private Plans ~ Payment

- Contract should:
  - Outline payment methodology
    - Seek specificity actual calculation, rate adjustments, service categories, etc.
  - Address prompt payment requirements
  - Define how payment will be made (check, EFT)
  - Describe overpayment or offset process

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Evaluating Financial Terms

- For commercial contracts, evaluate your direct cost of providing the service vs. the rates they are willing to pay
  - If you do receive less than your direct costs, then you lose money with each visit
  - Be able to track performance – after a few months, are we making or losing money with this contract?
- Don’t be afraid to walk away if necessary

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Medicare Advantage (MA)

- FQHC can attempt to negotiate agreement
- MA plans are not required to pay PPS rate (but they may choose to)
- CMS is required to provide supplemental (wrap-around) payments to:
  - FQHCs that contract with MA organizations
  - To cover the difference, if any, between the payment received by the FQHC for treating MA enrollees and the payment to which the FQHC would be entitled to receive (PPS)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf

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Medicare Advantage Typical Approaches

Approach One	• Contract and bill as a “physician group” • Receive fee-for-service or capitation payments
Approach Two	• Contract and bill as an FQHC • Receive payer defined “FQHC encounter rate”
Approach Three	• Contract and bill as an FQHC & include non-FQHC services • Receive a payer defined “FQHC encounter rate” & fee-for-service payments

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Medicare Advantage (MA)

- In order to request a rate for supplemental or wrap-around purposes the MA contract needs to:
  - Be between the FQHC and the plan
  - Include contract id numbers
  - Clearly describe payment terms
  - Fully executed

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf

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Importance of Contract Monitoring Process

Negotiation Consideration

- Leverage depends on multiple factors including:
  - Provider members in market area
  - Number of attributed patients or members in geographic market
  - Number of providers, specialties and service offerings
- Adopt payer perspective
  - Reduce cost
  - Ensure access
  - Demonstrate quality

Contract Renewal

- Many contracts have automatic renewals (evergreen provisions)
  - Review is still important prior to renewal date
  - Incorporate fee escalator
- If defined expiration date
  - Attempt to mitigate delays in renegotiation
  - Initiate process early
  - Communication contract termination consideration if renegotiation not completed

Fee Schedule

- Ensure reimbursement terms can be verified by the health center
- Includes:
  - Calculation
  - Service category variances
  - Updates

Health Center Specific Items

- Contracts may prohibit waiving or reduction or patient financial responsibility
- Contract may require specific professional liability coverage
- Both items need to be addressed

Formal Contracting Plan

- Proactive approach to managing payer relationships
- Designated Individual/Team
- Negotiation Strategy
- What's important to the health center? What are deal breakers?
- Tracking:
  - Active list of current contracts (identifying products and initial effective date and last negotiation date)
  - Expiration & renewal dates
  - Payment terms and provisions (maintain current fee schedules by CPT code)
  - Payer "headache" factor

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Let’s Talk…

Q&A

Contact

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Thank you!