Strategies for HIV Medical Providers Contracting with Health Insurers

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Many previously uninsured or underinsured people will have expanded access to health insurance through the Affordable Care Act (ACA). This guide provides physicians and medical practices with basic information to help them successfully navigate the rapidly evolving health insurance market. It is designed to:

- Expand access to quality HIV care by ensuring that physicians and medical practices retain their patients with HIV and attract new patients into their practices.
- Ensure that experienced HIV medical providers receive sufficient third-party reimbursement to adequately cover their costs.

The guide outlines eight steps for contracting with health insurance plans and managed care organizations (MCOs).

Steps for Contracting with Insurance Plans and MCOs

1. Check with Your Institution Regarding Their Health Plan Contracting Process
2. Identify Opportunities in Private and Public Health Insurance
3. Gather Information About Insurers
4. Assess Insurer's Track Record
5. Understand How Insurers Will Pay for Services
6. Evaluate Adequacy of Payment Based on Actual Costs
7. Contract with Public and Private Insurers
8. Assess Payoffs and Pitfalls

THE BASICS

The ACA expands access to health insurance in several ways:

- On Oct. 1, 2013, enrollment will begin in the Health Insurance Marketplaces created by the ACA for coverage effective beginning Jan. 1, 2014.
- Health insurers are required to offer, at a minimum, **Essential Health Benefits** (EHBs). Some individuals may need to change their insurance plan if their coverage does not meet the EHB standard.
- Health insurers are prohibited from discriminating against individuals with pre-existing medical conditions, such as HIV infection. In the past, these individuals were excluded from enrolling in some private insurance plans, had waiting periods before they could enroll, or had to pay high premiums. Individuals with pre-existing conditions may now purchase insurance through a Marketplace.
- Low income individuals in at least **25 states** plus the District of Columbia will gain health coverage through the expansion of Medicaid benefits to individuals with incomes up to 133 percent of the Federal Poverty Level (FPL), or around $15,000 a year for an individual.

Step 1. Check With Your Organization's Executive Management if You Practice in a Hospital, University, or Community Health Center

If your clinic is part of a larger institution or program, contact the appropriate staff within your organization to determine the health plans they contract with and inquire about whether HIV-specific issues have been or will be addressed in the health plan contracts. HIV-specific issues to consider addressing in contracts include:

- Payment levels that cover the cost of your HIV practice.
- Coverage of HIV antiretrovirals (ARVs) and other HIV-related medications, and HIV procedures including CD4 count testing, viral load tests, genotype and phenotype resistance tests.
- Coverage for HIV testing more than once per year.

Step 2. Identify Opportunities to Participate in Private and Public Health Insurance

There are several approaches to identifying health insurers that operate in your state:

- Check with your state's Health Insurance Commissioner to identify health insurers licensed to operate in your state. The National Association of Insurance Commissioners' **website** provides information and related links for each state.
- Target insurers participating in the **Health Insurance Marketplace** in your state to provide continuity of care to your patients transitioning to Marketplace coverage. Information on plans participating in the Marketplaces is available from the American Academy of HIV Medicine (AAHIVM) **website**. If your practice is located near a state border and you serve patients from more than one state, learn about private and public insurers in all of these states as well.
- Enroll in your state's Medicaid FFS program and/or contract with the Medicaid managed care organizations in your state. Check your state Medicaid **website** for information in addition to the AAHIVM **website**.

Step 3. Gather Basic Information About Insurers and Their Provider Networks

Providers should gather basic information about insurers before joining their networks. Most but not all insurers maintain websites with details about covered benefits, service areas, existing primary care and specialty networks, medication formularies, and hospitals participating in their networks.

SPECIALTY CARE: Insurers commonly list on their websites the clinical and other providers participating in their networks. Review the insurer's provider network to determine whether the providers commonly serving your patients are available in the network.

PHARMACIES: Key questions to consider when evaluating the retail pharmacies included in the health plan network:

- Are you familiar with the pharmacies participating in the insurer's network?
- Are the pharmacies conveniently located and accessible to your patients?
- Is mail order delivery of medications available? Is it required?

INPATIENT HOSPITALS: In reviewing the inpatient hospitals consider the following:

- Are you familiar with these facilities?
- Do you have admitting privileges with these hospitals?
- What is the hospital's track record for notifying you that your patients have been admitted?
- What is their track record for coordinating inpatient discharges to ensure continuity of care?

INSURER'S POLICIES AND PROCEDURES: Insurers commonly post important information on their websites, including provider policy and procedure manuals, utilization and authorization procedure guidelines, and standard provider contracts. State Medicaid programs also often post their model managed care contracts on their websites.

Many health plans use the Universal Provider Data Source for their credentialing process. **Learn More.**

After reviewing the materials, issues to consider discussing with provider relations representatives are noted below.

Payment Rates:

- Can we negotiate contract items with your plan?
- What payment mechanisms does your plan use to pay for office-based primary care providers? What payment mechanisms are used for specialty providers?
- Can I get a list of the FFS payments by Evaluation and Management (E&M) code for office visits?
- Are enhanced payments available for care coordination? How do we apply for those enhanced payments?
- What is the plan's policy for timely payment? What is your plan's rate of denied claims for primary care visits? For infectious disease visits?

Access to HIV Providers/Specialty Care:

- As an infectious diseases provider [or HIV primary care provider] – are referrals required for patients with HIV to see me?
- Can HIV specialists serve as primary care providers for their HIV patients? Does the insurer recognize HIV as a specialty or subspecialty?
- What is the plan's credentialing requirements for primary care providers, infectious disease specialists, nurse practitioners, physician assistants [or other clinicians in your practice]?
- What access standards must the provider address? For example, does the insurer have requirements regarding hours and days of operation, coverage during evening and weekend business hours, after-hour and on-call coverage when a designated provider is unavailable, maximum waiting time for an appointment, required intervals for providing specific services, and maximum waiting-room times?
- *For private plans in the Marketplace*: I receive Ryan White funding and am considered an Essential Community Provider (ECP). What is the process for contracting as an ECP?

Coverage and Benefits:

- Who determines medical necessity? Where are the criteria posted? What is the process for reconsideration of a determination that a service is not a medical necessity?
- What is the plan's policy for covering HIV ARVs? Is an HIV or infectious diseases physician on the committee that makes formulary decisions? Is prior authorization required?

Coverage and Benefits:

- What is the plan's policy for covering CD4 count tests, viral load tests and genotype and phenotype resistance tests?
- Does your plan cover HIV testing? If so, is there a restriction on the number of HIV tests that may be covered per year?
- Are disease managers or case managers routinely assigned by your plan to patients with HIV? What is their role in coordinating care? What are their clinical training requirements and expertise?
- What utilization management and review procedures does the insurer employ?

Quality and Reporting:

- Does your plan have HIV-related quality measures? If so, can you send me a copy of those measures?
- What are your reporting requirements for providers?
- *For Medicaid plans:* Can you send me the most recent report summarizing the plan's clinical quality measure performance for services provided in this state?
- *For private plans:* Can you send me the most recent report summarizing the plan's Healthcare Effectiveness Data and Information Set (HEDIS) performance for services provided in this state?

Step 4. Assess the Health Insurer's Track Record

Reach out to colleagues in other HIV clinics and infectious diseases practices as part of your evaluation process. Inquire about:

- Their perceptions of the insurer.
- The insurer's willingness to negotiate contracts with HIV clinics and ID practices, including enhanced HIV payment arrangements.
- Adequacy and timeliness of payments.
- Financial stability.
- Propensity to deny claims because services were deemed not to be medically necessary.
- Coverage of HIV testing, ARVs and other HIV-related medications, and HIV-related lab tests.
- Use of disease managers to reduce inappropriate HIV-related care and mental health and substance abuse treatment.

Step 5. Understand How Health Insurers Will Pay for Your Services

This section provides an overview of the most common payment methods used by private and public health insurers.

FEE-FOR-SERVICE (FFS): FFS continues to be commonly used by private and public insurers. FFS payments are made for each service provided to a patient. Each specific service provided is billed to the insurer after the service is provided, i.e., retrospective payment. FFS payments are set through formulas or negotiated with providers. Claims for FFS payments are commonly submitted using coding systems, such as Common Procedures Terminology (CPT), International Classification of Diseases (ICD), and Health care Common Procedure Coding System (HCPCS) Level II.

The ACA increases Medicaid reimbursement for primary care services up to 100% of Medicare payment levels for 2013 and 2014 for family physicians, internists, pediatricians, and subspecialists. The increase is not tied to a state's decision to expand Medicaid. All state Medicaid programs are implementing the enhanced rates for primary care services. Services furnished by non-physician practitioners under the supervision of a qualified physician also qualify for the higher fees. **Learn More**.

CAPITATED PAYMENT SYSTEMS: Capitation is a fixed payment per patient, per unit of time (usually per month), paid in advance to the provider for the delivery of health care services. The amount paid is typically based on the types of services provided, number of patients assigned to the physician, and period in which the services are provided. Capitation rates are commonly computed using historical local costs and an average rate of service utilization and often vary among service areas. When the provider signs a capitation contract with an insurer, a list of specific services that must be provided to patients is identified in the contract.

Insurers may establish a risk pool in which a percentage of capitation payments are withheld from the provider until the end of the contract period. If the insurer incurs a profit at the end of the contract period, payment is made to the provider. Alternatively, if the insurer does not break even in the contract period, the withheld funds are used to pay the deficit. Insurers commonly purchase "stop loss" health insurance policies that take effect after a certain amount has been paid in claims in a specified period. Such insurance protects insurers from higher than projected claims or catastrophic claims for insured patients with significantly higher than average claims. Premiums are based on the number of insured patients, their age and other information.

BUDGET-BASED PAYMENT SYSTEMS: Budget-based payment is designed to achieve specific cost targets and outcomes. Payments are tied to providers' ability to successfully predict future utilization for insured patients based on the past utilization of patients with similar characteristics and costs associated with providing covered services. Providers must ensure that the costs of their covered patients do not exceed the budget offered by the insurer. Insurers use historical expenditure data to calculate projected utilization based on the number of covered individuals or lives, their health status, and the array of services to be provided by the contracting providers. These factors are used to calculate actuarially sound per member, per month (PMPM) capitated rates. The rates are commonly risk adjusted to account for age, gender, geographic area, clinical acuity, diagnoses, co-morbidities, or other patient characteristics.

PRIMARY CARE COORDINATION PAYMENTS: Insurers may pay primary care providers a fee, typically on a PMPM basis to cover services related to coordinating care that are not compensated through other payment mechanisms. Payments to primary care providers are commonly set through a formula or negotiated by the insurer with participating organizations.

PAY FOR PERFORMANCE: Pay for Performance (PFP) supplements FFS payments with bonuses to physicians to achieve defined and measurable goals for care processes, physician performance, clinical outcomes, patient experience, and resource utilization. The insurer evaluates performance by comparing performance criteria with claims quality and cost data from participating physicians or practices. Insurers may also consider use of electronic health records, electronic prescribing systems, care management, capacity to report quality data and patient satisfaction data.

SHARED SAVINGS: Shared savings models are used by private and public insurers, including the Medicare Shared Savings Program established by the ACA. Under this model, when the cost of care received by patients is lower than budgeted, the provider receives a percentage of the difference between actual and budgeted costs. If actual costs exceed the budgeted amount, the provider may or may not be responsible for a portion of the difference. If a shared savings agreement is limited to "upside risk" – the provider receives additional revenue if health care costs are lower than budgeted. Under a "downside risk" arrangement, a provider receives a percentage of savings if expenses are lower than budgeted, but also is at risk for incurring additional expenses if actual costs exceed budgeted costs.

GLOBAL PAYMENTS: The global payment model applies a single payment to cover all services provided to a defined population in a defined period. The model builds on capitation payments by adjusting payments based on the results of performance measures and risk adjustment. Although the model pays a bonus based on documented savings, the provider receiving a global payment assumes financial risk for higher-than-expected costs.

CONDITION-SPECIFIC CAPITATION: In this model, a comprehensive care payment is paid to cover all care management, prevention services, and minor acute services related to a patient's chronic illness. Condition-specific capitation rates are developed based on the patient's clinical acuity and other characteristics. State Medicaid programs, including New York and Maryland, have used condition-specific capitation models for patients with HIV infection.

ACCOUNTABLE CARE ORGANIZATIONS: Accountable Care Organizations (ACOs) were adopted by the ACA as a major reform model. ACOs are provider collaborations that integrate physicians, hospitals, and other health care providers to receive additional payments by achieving quality targets and incurring reduced overall spending for a defined patient population. The ACA requires ACOs to be responsible for the continuum of care. ACO models may be organized in different ways, ranging from fully integrated delivery systems to networks of physicians in small practices who collaborate to improve quality, coordinate care, and reduce costs. ACOs may adopt different payment incentives, from FFS payments to limited or fully capitated models with quality bonuses.

Step 6. Evaluating the Adequacy of Payment Systems Based on Your Costs

RESOURCES TO HELP PRACTICES CALCULATE UNIT COSTS: The American Medical Association (AMA) has developed tools to help practices calculate costs, using the Centers for Medicare and Medicaid Services' (CMS) Resource-Based Relative Value Scale (RBRVS) and Relative Value Units (RVUs). Twelve steps are used to calculate a practice's cost per RVU, and aggregate costs can then be calculated based on the RVU value of each service. These tools are **online**.

In the 1990s, the HIV/AIDS Bureau (HAB) funded the development of the Technical Assistance Costing Tool (TACT), which is still relevant today. The tool is an Excel-based spreadsheet that guides providers in identifying and entering components of service cost. The TACT uses basic patient information to calculate patient care expenses and provides cost information that can be used for billing and reimbursement. The tool is available **online**. **Learn more**.

Step 7. Contracting With Private and Public Health Insurers

Several critical steps are necessary in undertaking contracts with health insurers.

SEEK LEGAL ADVICE: Obtain experienced legal counsel to help guide you through the contract negotiation process.

PREPARE TO NEGOTIATE: Identify services required by the ACA or Medicaid MCO contracts that you can offer to the insurer. For example, offer infectious disease or other specialty services for which the insurer may have insufficient network capacity. Most Marketplace Qualified Health Plans must include some Ryan White Program-funded providers to meet the Essential Community Provider requirement. Be prepared to provide the insurer with data demonstrating your ability to deliver high quality, cost-effective services, to serve high cost or other priority populations, to monitor and control utilization, and to apply cost containment procedures.

CAREFULLY EVALUATE THE CONTRACT: Fully understand the contract offered by the insurer. Questions in evaluating key contract areas are noted below.

Contract Terms:

- What is the term (time period) in which the contract is in effect? Does it include automatic renewal provisions or annual rate negotiations?
- Does the contract clearly define the scope of services to be provided? Does the contract or its attachments clearly identify the covered services available to enrollees?
- What is the termination clause, and how much notice must be given to the provider?
- What is the renewal procedure?
- Does the provider have the right to review and approve amendments to the contract?

Coverage and Benefits:

- What procedures should the provider use to determine patient eligibility for services covered by the insurer (e.g., electronic or telephone verification)?
- Are referral policies, procedures, and timelines clearly spelled out in the contract or attached and incorporated by reference?
- Does the contract allow the provider to determine whether and when to make referrals for specialty care or hospitalization?
- Is coordination of benefits the responsibility of the insurer or the provider? How do you determine which plan is the primary payer?
- What requirements does the contract specify for the provider about charging enrollees for non-covered services (e.g., non-covered services, co-pays, deductibles)?
- Does the contract impose any limitations on the provider's practitioners from advising an enrollee about the patient's health status or treatment options; risks, benefits, and consequences of treatment or non-treatment; and the opportunity for the patient to refuse treatment or express preferences about future treatment decisions? *Such a "gag clause" is sometimes inserted in contracts by insurers.*

Payment and Claims:

- What is the time frame for submission and payment of claims? Will the insurer pay interest on late payments?
- What are the insurer's requirements for "clean claims" submissions?
- Does the insurer require other data than what is submitted on a **CMS 1500** or **UB 92** form?
- What is the insurer's policy for over- or under-payments?
- What is the process for claims dispute resolution?
- What fee schedule is being used?
- Is payment adequate under the contract to cover all of the costs incurred in meeting the access and appointment standards?

Step 8. Assessing the Payoffs and Pitfalls of Contracting

During the first year of contracting with health insurers, providers should weigh the financial benefits of your contracts versus issues that arose with the insurer and their enrolled patients. Providers should consider not renewing a contract if the pitfalls outweigh the payoffs of the contract. Such issues might include:

- A small number of enrolled patients.
- Insufficient revenue to cover the administrative cost of network participation, such as staff time to research and resubmit rejected claims.
- Untimely payments or reimbursement that does not cover labor and overhead costs.
- Rejection of claims due to lack of medical necessity.
- Limitations on the number of medical visits covered for patients with HIV or other burdensome cost-controlling or utilization management policies, e.g., prior authorization or requirements for specialty referrals.

Ryan White Program funds **cannot** be used to pay for provider services if the provider is not in the patient's health plan network even if the health plan's terms are unreasonable. Ryan White funds can pay for services that are not covered or that are only partially covered by a plan if the provider is in the patient's health plan network. See the Ryan White Program's payer of last resort policies, including Notice 13-04 Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by the **Ryan White HIV/AIDS Program**.

LEARN MORE

AMA's National managed Care Contract

The AMA offers training webinars and other resources to help physicians undertake MCO contracting, including the National Managed Care Contract (NMCC), which is designed to comply with federal, state, and District of Columbia managed care laws. The NMCC covers the business relationship between physicians and MCOs. The NMCC also helps physicians and their attorneys better understand, evaluate, and negotiate managed care contracts. You can search and compare model contract language, review issue briefs on important managed care topics, and find the full text of state and federal managed care laws. These resources are **online**.

IDSA Manage Your Practice Resources

IDSA compiles clinical practice-related information for infectious diseases physicians and their staff. Resources include information about billing and coding, Medicare's Physician Quality Reporting System, practice management forms and documents and much more. **Learn more**.

Additional Resources and References

CMS. Medicaid Provider Payment Provisions Under the ACA.
http://www.medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html
CMS. Documentation Guidelines for Evaluation and Management (E/M) Services.
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html
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HAB Policy Notice: 13-05 Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance.
HAB Policy Notice: 13-04 Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program.
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AAHIVM - Health Reform in My State
http://www.aahivm.org/chapter/exec/healthreformbystate

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This guide was prepared by Positive Outcomes Inc. in collaboration with the HIV Medicine Association.