HFMA Career Center

HFMA CHFP Certification Series
Article 6 - Contract Management

The finale module in the certification preparation materials is *Contract Management* The module comprises 13%-17% of the certification examination. Knowledge and skills assessed in this contract management area:

- Key components and common terms of a contract
- Key components and common terms of a healthplan/payer contract
- Be able to discuss criteria-based contracting and create an evaluation model

Contracts are used to define terms between two or more parties for the provision of a service or product. In healthcare, contracts are used for construction projects, collection services, maintenance on equipment, leasing space, contracted nurses or other staff, and a variety of other items. For a contract to be valid, two (or more) individuals:

1. must agree to the provisions of the contract,
2. must agree to the price (or promise),
3. be legally competent or authorized to enter into the contract, and
4. the contract must be for services and products that are legal.

There are four steps to assessing a contract:
Assessing a contract-

1. Understand legal terms
2. Read the contract for the financial benefits it offers
3. Summarize the 'gives' and 'takes' of the proposal
4. Identify loopholes

In most contracts there are "boiler-plate" clauses. Boilerplate provisions are important because they affect your and the other party's rights. These provisions or clauses are common to most contracts. Can you define them and state their purpose?

1. The purpose of boilerplate provisions is to save the parties and drafters of contracts time with commonly used language.
2. Although, the clause may be labeled as a boilerplate provision, it can still be tailored to meet your specific contracting requirements.
3. Always read ALL sections of any contract before signing it.

Common Uses of Contracts in Healthcare Finance
Contract use in healthcare finance is extensive: note the range of functions and responsibilities that can be contracted:

- Services of an external auditor
- Health plan/payer contracts
- Banking services
- Collection agency
- Contracting for temporary billers or other staff
- Engaging a scanning company to scan files and destroy paper files
- Equipment maintenance (shredders, copiers, printers and other equipment)
- Maintaining applications by providing upgrades to and education for the software used

Much of this module is focused on health plan/payer contracts since they have a significant impact on healthcare finance. Healthcare financial managers often are involved in evaluating, developing, and monitoring contracts between the healthcare organization (HCO) or provider and the health plan/payer. These provider/health plan/payer contracts may be between:

- indemnity/commercial insurers,
- preferred provider organizations (PPOs),
- managed care organizations (MCOs) such as health maintenance organizations (HMOs), exclusive provider organizations (EPOs), and accountable health plans (AHPs), or other health plan/payer related entity

Common contracting provisions

This next section highlights common health plan contract provisions and definitions. Common contracting provisions include:

- Claims submission requirements
- Clean claim requirements
- Claims payment requirements
- Definition of day in per diem contracts
- Definition of emergency services
- Incorporation of other documents
- Access to data
- Unilateral changes
- Cost of living rate adjustments
- Retrospective Payment Denial
- Dispute resolution
- Allowance/prohibitions against litigation
- Appeals

The definitions and operating implications of these common provisions are highlighted here:

- **Claims Submission Requirements.**

A typical healthplan/payer contract will define the claims submission parameters for providers to obtain payment. These parameters include defining a timeframe for claims submission (e.g., 45 days). The standard timeframe varies by health plan and by state. It is important that providers and healthplan/payers be aware of any statutes within their state (typically falling under the prompt payment laws) that define specific claims submission requirements.

- **Clean Claim.**

Another typical parameter of claims submission is the requirement to submit clean claims. A clean claim is generally defined as a claim that includes all of the necessary data fields for a healthplan/payer's system to be able to properly process the claim. It is important for providers that the definition of a clean claim be clearly defined in the contract (preferably in the definition section).

- **Claims Payment Requirements.**

The contract should include specific requirements for health plans to pay claims within a defined period (for all claims that have met the submission requirements). Almost all states have established timeframes for payment in their prompt payment laws.

- **Definition of Day in Per Diem Contracts.**

When payments are made under this structure, it is important for providers to avoid language defining a day as "in the 24-hour period before the midnight census."

- **Definition of emergency care**

The provider should be mindful to avoid language requirements to seek preauthorization for the provision of emergency services in violation of EMTALA

- **Incorporation of Other Documents (Provider Manuals, Plan Policies, and Procedures)**.

It is typical that this document be separate from the actual contract because it is often necessary for healthplan/payers to update their policies and procedures to meet state, member, provider, and other market factors requiring change.

- **Access to Data**

Both health plans and providers gather specific patient and member data that is important for the other to access.
These data include claims payment data, member eligibility data, member demographic data, patient service authorization and referral data, and other information.

- **Unilateral Changes.**

Certain policies and procedures will need to be amended by the health plan to meet regulatory requirements and changing market demands.

- **Annual Cost-of-Living Rate Adjustments for Multiyear Contracts**.

It is reasonable for providers to negotiate annual Consumer Price Index (CPI) (or inflation) adjustments to rates for multiyear contracts.

- **Retrospective Payment Denial.**

Most states have laws or court decisions restricting health plans from retroactively denying payment for claims for which coverage was verified or services were preauthorized (except in cases in which the member was ineligible for coverage).

- **Dispute Resolution.**

A standard contract may call for binding arbitration as the method for resolving disputes.
An arbitration proceeding is similar to litigation.

- **Allowance or Prohibition against Litigation.**

Providers have increasingly pursued litigation over the past several years to settle disputes such as underpayments, late payments, and other allegations of contract breach.

- **Appeals.**

The standard contract should include language describing a fair and objective appeals process for the provider to appeal adverse payment decisions on a day-to-day basis.

The written contract between the provider and healthplan/payer defines the rights and obligations of the parties under the health plan/provider relationship. It is important that the parties review:

- Contract language
- Reimbursement levels
- Financial, operational, and legal parameters acceptable to both parties

Evaluation criteria should be established by management to identify and prioritize desired contract features *before* entering contract negotiations. Once the criteria are established, then a model for evaluating the proposed contract can be created. A strong contract evaluation model breaks a contract down into parts and examines the following:

- Payment rates
- Covered lives
- Claim complexity

- Preapproval/utilization review requirements
- Carve- outs
- Risk for the provider

The value of an evaluation model? The benefits to such a model include:

- It Allows the proposed healthplan/payer requirements to be compared against and scored to criteria (preferences or ideals) established by the provider
- It summarizes the degree to which a proposed contract satisfactorily meets the provider's expectation
- The model and evaluation process helps the organization to stay focused on its goals
- It avoids contract ambiguities or concerns later.