



Aligning Contract Language, Intent Structure and Repricing Capabilities

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❖ **OVERVIEW**

- **Challenge**

Healthcare organizations struggle with ambiguous, misleading and/or contradictory language in their provider contracts, leaving stakeholders on both side of the relationship frustrated in efforts to define *intent*. Compounding the problem is the occasional absence of qualification of services (i.e. it is insufficient to state that Screening Mammography pays \$114 per visit without defining the service as revenue codes 401 and 403). In addition, health plans too often find business rules in their contracts that exceed their technical capabilities to *reprice* these rules.

- **Solution**

Health plans and providers gain a mutual benefit when they work to aggressively identify sub-standard contract language and proactively modify these terms such that a reasonably intelligent person can fully understand the intent of the language, the definition of important terms, and the absolute qualification of services and quantification of payment values.

Bridging the gap between contract intent and a health plan’s repricing capabilities requires technology that can both accommodate very complex business rules (those that current pricing technology cannot accommodate) and allows for modeling of alternative rules that the plans repricer *can* accommodate.

- **Benefits**

Clear and concise contract language avoids the cost of retroactively interpreting the author’s intent in an effort to arrive at a consensus, serves to enhance provider relations and avoids the expense of “re-working” claims.

Aligning contract intent with the health plan’s repricer capabilities leads to cost savings as a result of a higher percentage of auto-adjudicated claims, to the mutual benefit of both the health plan and the provider.

March Hare: Then you should say what you mean.
Alice: I do; at least - at least I mean what I say -- that's the same thing, you know.
Hatter: Not the same thing a bit! Why, you might just as well say that, 'I see what I eat' is the same as 'I eat what I see'!
March Hare: You might just as well say, that "I like what I get" is the same thing as "I get what I like"!
The Dormouse: You might just as well say, that "I breathe when I sleep" is the same thing as "I sleep when I breathe"!

Through the Looking Glass, Lewis Carroll

- **Contract Intent**

At one time or another we are all guilty of misstating in the written word that which we intended to communicate. Parties to managed care contracts experience the frustrations of vague, ambiguous or contradictory language in provider contracts on a fairly regular basis. The questions arise: Who is to be the arbiter when the question turns to *intent*? In the event that large dollars are in play, what is the best strategy for the parties to employ? How important is the provider / payer in this particular market? Why are we in this predicament in the first place?

In many managed care contracts there is a serious disconnect between the contract language relating to the payment rates and the *intent* of that language (not to mention the disconnect between contract terms and the health plans ability to *reprice* these rules; more on that later.). This is curious insofar as we work in an industry that demands substantial specificity in the course of business operations. Edits abound to ensure that claims data is logical, complete and in accordance with recognized formatting standards. Processing of claims requires that every byte of data is stored in a very specific, predefined sequence. Coding methodologies (DRG's, revenue codes, CPT's and ICD-9's) provide the ability to define virtually any service or "item" that could be provided to a patient. Why then the ambiguity in payment terms?

Contract language must be carefully crafted and defined within the Agreement, utilizing current coding methodologies and/or other clearly defined criteria in such a way as to leave no ambiguity as to the service being defined. The alignment of language and intent (relating to payment terms) is critical because this language is designed to serve as the "price sheet" for services offered by the provider. Absent this alignment, foreseeable and avoidable difficulties are needlessly interlaced into the relationship.

- **Qualification and Quantification**

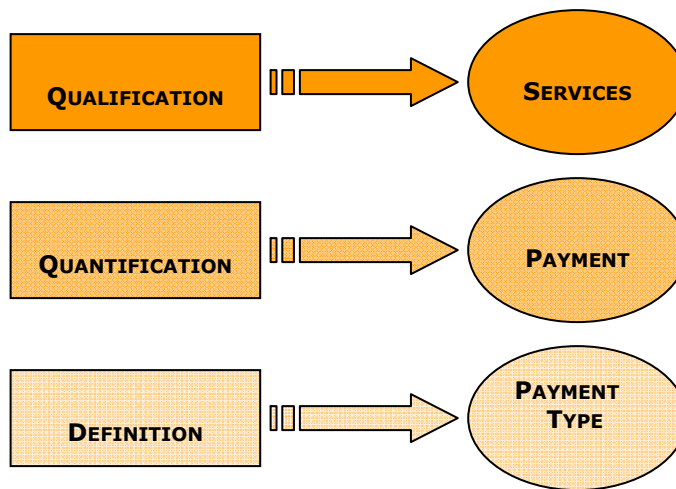
For the purposes of clarity between *all* parties to the contract¹, *every* business rule in a contract should require qualification and quantification before the parties sign off on the contract. By qualification we refer to the various coding methodologies (DRG, revenue code, ICD-9, CPT, etc.) as well as other measurable criteria that may be employed by the parties (age, dollar thresholds and triggers, maximum frequencies, etc.) which define the service or product. Quantification simply refers to the negotiated reimbursement value. Applying strict qualification and quantification standards will also lead to a higher percentage of electronically priced claims, allowing your repricing technology to work for you the way it was intended.

¹ In addition to the parties negotiating the contract, additional parties to the contract can include: claims, network management/provider relations, IT, actuary, revenue identification staff (internal and external), recovery staff and legal.

• **Definitions**

Various payment types are employed in managed care contracts including per diem, per visit, per unit, case rates, percentage payments, carve outs, exclusions and outliers. It is neither sufficient nor wise to assume that the parties define these terms in a like manner. Each of these terms therefore requires a definition. By example:

Per Visit Payment: The flat rate payment made to the provider for all covered services provided to a member on one calendar day period for each outpatient service category listed in this appendix. Unless otherwise stated, the Per Visit payment is considered payment in full for all services rendered. Provider is responsible for identifying each date of service when submitting claims spanning multiple dates of service.



• **Ambiguity**

Ambiguity in business rules often leads to a minimum of two competing and valid interpretations. Such incidents are more common than one would think. In one example, a contract clearly stated that orthotics and implants (revenue codes 274, 275, 276 and 278) were to be paid in addition to other payments at the rate of 50% of eligible charges and that charges for these items were to be excluded from, or “passed through”, the calculation of outlier threshold. Later in the contract, high cost items were addressed again but also included high cost drugs (revenue codes 634-636). However, in this latter wording, nothing was said about the pass through issue (though the paragraph was titled “Exclusions”). That left the issue relative to high cost drugs ambiguous. As the scenario played out, the provider interpreted that charges for high cost drugs were not to be “passed through” and the health plan, concerned about its relations with this provider, paid the facility for “outlier” claims previously paid as non-outlier. Of course, this situation was completely avoidable.

For the purpose of assessing intent on the outlier pass through (or Exclusion Rule), our argument has always been that if a service is singled out to pay “in addition to other payments”, charges for said services cannot also be included in the outlier threshold calculation. This seems logical in that otherwise the services trigger two distinct business rules: 1) payment “in addition to other payments” and 2) outlier payment logic. As in the example above, intent is too often defined after the contract is executed, when reason can take a second seat to financial interests.

- **Complexity**

Some degree of complexity is inherent in the world of managed care contracting as stakeholders seek to protect their interests and perhaps pressure is imposed by a dominant party. However, problems arise when the structure of a "business rule" outstrips the capacity of a health plan's repricing technology. One health plan we know of manually prices every ambulatory surgical center claim due to the technical limitations of their repricer. Another plan shared with us that an increasing number of facility contracts exceed the plans repricing capabilities. Such circumstances can lead to significant, and potentially avoidable, costs to the plan.

In another instance, an outlier business rule established that the threshold was three times the DRG case rate. In so doing, this contract dictated over 550 threshold variables, unique to each DRG. Very few repricers can adjudicate such logic and a valid argument can surely be made that there are reasonable alternatives to such a rule.

Circumstances like these equate to a disservice to all stakeholders. Manual claims pricing increases the plans administrative costs while arguably resulting in greater numbers of incorrectly calculated payments (in the ASC circumstance above, the plan subjects these claims to 100% manual audit). It is essential that contracting specialists fully understand the limitations of the plan's technology and structure "business rules" that conform to these parameters. A greater conformity between business rules and technology yields a higher percentage of auto-adjudicated claims. Logically, this should result in a lower percentage of mis-priced claims. This in turn increases payment accuracy, to the mutual benefit of the stakeholders. The question becomes: "How do I get there"?

Alice: Would you tell me, please, which way I ought to go from here?

The Cat: That depends a good deal on where you want to get to

Alice: I don't much care where.

The Cat: Then it doesn't much matter which way you go.

Alice: ...so long as I get somewhere.

The Cat: Oh, you're sure to do that, if only you walk long enough.

Through the Looking Glass, Lewis Carroll

• **The Contract Modeler as an Accommodator and Contract Driver**

Effective modeling technology has two interfaces with differing structures: Baseline and Modeling. "Baseline" accommodates the currently active contract and will accommodate nearly any conceivable business rule. All the *models*, however, are limited to employing those business rules that can be adjudicated with the health plan's current repricing technology. There can still be significant flexibility and choice within the available model options, but the structure is designed to ensure that only rules which current health plan technology can accommodate find their way to the final contract (subject to management's discretion).

The contract modeler as an accommodator is accomplished through a re-engineering of the contract loading tool (which is an integral part of the modeling environment). An inventory of the health plan's repricer capabilities defines its operational parameters. These parameters are then mimicked in the contract loading tool such that only those business rules that fall within the operational parameters may be used in structuring the model (and ultimately the new contract). Using this strategy, health plans can more effectively manage the definition of approved business rules (those which its technology can accommodate), yet allow for considerable flexibility in the structure of contracts.

Effective modeling technology forces the applications of quantification and qualification. That is, entering rules requires that salient elements of the rule are defined before the rule will be accepted by the system. In an example of entering a DRG based rule, users would be required to define:

Business Rule Properties	Values
Type of Stay	Inpatient
DRG	370
Payment Value	\$3250
Not to Exceed %	1 (100% of billed charges)
Not Less Than %	0 (No minimum payment as percent of billed charges is defined)
Payment Type	Case Rate
Exclusivity	Yes (Case Rate is payment in full)
Step Down	No (Does not use Case Rate with step down to Per Diem)
Carve Out Status	No (Charges are not carved out of threshold level defining Outliers)
Group	C-Section (Populated to Contract Summary for transparency)

Once the data is entered, the system validates that the values are present and are within acceptable parameters, then records the business rule to the repricer. In this manner, contracts can be designed to the satisfaction of the stakeholders while actually *driving* the structure of the contract within the operational parameters.

- **Transformative Modeling**

Modeling is an effective way to migrate from complex and ambiguous business rules to terms which the health plan's technology can accommodate while still addressing the concerns of the stakeholders. Using the current contract and actual claims data, a baseline is established that accurately reflects the current reimbursement levels for a particular provider and product(s). Subsequently, modeling allows for the introduction of new business rules and the adjustment and/or deletion of current rules to achieve a "reimbursement neutral" alternative contract. This process allows the health plan to re-configure the contract in a manner that its repricer can accommodate, creating the necessary alignment between business rules and technological capabilities. Ultimately, one of the models becomes the operative contract, so the modeler becomes a tool that actually defines the contract terms as a reflection of the health plan's repricer technology.

This process is enhanced when the provider has confidence and an understanding of the process of this contract "paradigm shift", while also recognizing the benefits to be derived (i.e. greater auto-adjudication rates result in fewer payment errors). Model summaries, reflecting the business rules and proposed payments, should be able to be shared with the provider in hard copy and electronically. In fact, the provider should be part of the entire process either in person or via web conferencing technology.

Model summaries often reflect unintended and unanticipated reimbursement, a phenomenon we call "reimbursement dynamics". This occurs, for example, when outlier thresholds are adjusted or when new rules are introduced or current rules deleted. Claims that were formerly adjudicated under one rule are now paid under another, presumably at a different rate. The results of simultaneous and multiple additions, deletions and adjustments to a contract cannot possibly be intuited; this demands a sophisticated, interactive software solution.

Transformative modeling requires powerful repricing technology because in order to bridge the gap between the "non-accommodated" contract and the "accommodated" contract, the repricer needs the capacity to accommodate the former, more complex business rules (such as the DRG outlier threshold discussed above) plus have the ability to create models under a completely different structure than the Baseline. When shopping for such technology you will be well served to "test" your most complex contracts with the vendor for actual contract load and pricing.

- **Transparency**

Ultimately, stakeholders benefit from contract terms and business rules that are understood by all the parties. Beneficial to the process is a clear, concise summary of the business rules that a layman can understand. A format which defines the rules in plain English (including carve out status, multiple code requirements, "pay in addition to" status, services exempt from outlier threshold calculation, step down logic, high cost payment trigger values, multiple procedure ASC payment rules, not to exceed percentages, not less than percentages, excluded services, etc.) by service definition, qualifying codes and payment values goes a long way to ensuring the parties understand all of the payment rules of the contract. The time to clarify intent is prior to contract execution, not at some later date which then potentially requires considerable re-work of claims on behalf of the health plan.

Doorknob: Read the directions and directly you will be directed in the right direction.

Through the Looking Glass, Lewis Carroll

- **Summary**

The process of creating greater clarity in contract language requires a multi-disciplinary approach coordinated through a single individual (or group). There is nothing particularly difficult about achieving clarity when the parties to the contract (see footnote ¹) have available a single source to which they can submit observations made during the course of their work. The coordinator in turn works with network management to clarify intent of ambiguous terms, qualify services, quantify payment values and/or define terms as the case may be. Annotations can be made to electronic copies of the contracts to act as a “tickler” to address at contract renewal or action can be taken in a more timely fashion, as may be deemed appropriate by network management. In any event and by whatever means, it is important to remove ambiguity, confusion and contradictory language from provider contracts.

The process of alignment of contract intent and health plan repricing technology is a more complex issue. Modeling and transparency can afford a level of confidence providers may rightfully insist upon prior to paradigm shifts in contract terms and structure. The clarity of business rules and quantification of reimbursement levels (aggregate and drill-down) offered by more advanced modeling technology creates a greater probability of acceptance by the provider of paradigm shifts within the existing contract.

In the end, providers seek to be paid correctly and no less, while health plans endeavor to pay correctly and no more. Contracts that are clearly understood by stakeholders and which reflect business rules that the health plan can auto-adjudicate to a high degree do well to move the parties closer to this goal.

- **About Chart-Tech**

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