All Payer Day - Provider FAQ's/Specifics - For PAYER Presentations

GENERAL FAQ'S

The Payers with Exchange plans:

1) When an individual or employer buys a plan one line, how does that info get transmitted to the payer and how long does it take to become effective?
2) What is the rationale for narrow networks and will their strategy change any if the recent lawsuit (filed in Washington by a hospital who was excluded from a payer network) is successful?
3) What do they think about Private Exchanges popping up in communities across the country with very large employer groups?
4) Exchanges – Your part and thoughts
5) Provide card examples, especially for their new Exchange products. (how can we discern the difference)

Your Company's Plans and Future Changes:

1) Payor-Provider Collaborations for the future: What would they look like from their perspective?
2) Provider risk assumption - What kind of risk sharing are they looking for?
3) Population Health Strategies in Colorado - What might or will work? How are they changing behaviors?
4) What in their view is standing in way of integrated health systems from working directly with employers?
5) Even if ACA fails or is defeated the Health Care Reform train has long since left the station. Healthcare system will continue to reform and evolve " I know that because……?" (How would they finish this?)
6) What are their plans for ICD-10 testing and are they going to pick "test providers" or clearing houses to test with? Can a provider request to become a test site?
7) With respect to authorization and ICD-10, will they expect exact digits for DX and procedures or the actual medical terminology that describes the DX and procedure?
8) What are your:
    a. Major initiatives or new products planned for 2014?
    b. Are there any major improvements or changes planned for your web site?
    c. Are there any acquisitions, mergers or expansions planned?
9) P4P. Describe their plans and requirements- both hospital and physician. (additional contracting, claims based entirely, regular data submission, medical record review, all requirements and what do they offer for participation)

10) How do they expect provider participation if all plan requirements differ and expect full time staff in the provider office for completing this? Do they have options to partner with provider to assist? Do they have any plans to make these programs universal using a single reporting or database? How can the single Provider office apply staffing to do this?
11) Narrow networks. Wave of the future? Who gets in and who is left out?
12) What % of their members are covered by Self-Funded plans? (Therefore rules of the contract never apply)
13) Plans to bring outsourced jobs back to the US? (Everyone is tired of trying to work through the call to India or the Philippines)
14) Could they provide membership #s in different plans per county?

Revenue Cycle Concerns:

1) All-payor Claims Data Base - Are they participating? What is the value-add in their viewpoint.
2) Tracer 276/277. Do you respond to secondary inquiries?
3) Intentions for payment changes involving POA, Readmissions, etc. Payor reporting on such items now – how and when will these transmit into actual non-payment or action against provider?

Contract/Reimbursement Concerns:

1) Shifting away from Fee-for-Service reimbursement – Where are they heading first? (P4P, Bundled Payments, Global?) How many years do they expect the transition to take?
2) Can they follow Colorado Medicaid's lead and administer APR-DRGs? If yes, How soon?
3) Contract language versus Administrative guidelines that we have been told supersede contracts, please discuss process.
4) Any new payment methodologies in 2014? If so, what are they?
5) Will there be any significant medical or reimbursement policy changes in the near future?

SPECIFIC PAYER QUESTIONS:

Aetna

- Can you explain your reasoning behind paying ER claim levels solely on the physicians E&M level? The reality is that a facility E&M may be greater and more complex as a result of the treatment plan. This process cause's rework, which adds pressure to our limited resources.
- Why are claims split up? It doesn't seem like it's a dollar amount threshold or a line item count threshold

United Healthcare

- The UHC "Back page" AR created reconciliation process is very manual, confusing, and often cause balancing errors and rework. Can you provide any guidance on making this process more user friendly? At present, UHC is the only 835 that is difficult to balance.
- Medical Necessity – how has this changed operations, utilization management and claims payment?

Kaiser Permanente –

- The Kaiser EOB to providers is not user friendly when having to bill a secondary insurance because the EOB to provider does not have totals on any line. Totaling is a manual process. Moreover, the patient is provided an excellent EOB. Is there a reason why there is no total for provider? Is there a potential for change in the future?

Anthem

- Any chance customer service will come back from Manila or moved to a less depressed area. In my opinion, the area's weather and poor phone lines contribute to several dropped calls. Billers enter all the requested customer service information, and hold for customer service just to hear an automated voice saying, "Thank you for calling – Good bye".
- EOB's for zero pay (applied to deductible) not being sent to provider specifically plan alpha EIL, XFL and XFW we are having to request from the plan to get the EOB so we can post contractual and move to patient responsibility. We can get some from the website but some we cannot and it is required by our contract that they provide EOB's.
- Credits balances and take backs; what is the dollar threshold and timeframe?

Novitas –

- MSP issues such as, claims suspending because systems can't handle MSP claims, when can we expect it to be resolved?
- What is the correct way to bill conditional payments billing manual states after 120 days but the claims system denies claims for out of timely if billed past 120 day mark?
- 51 MUE issue (reason code CO -151), line items are denying for this reason erroneously, another system issue since March, when can we expect resolution?
- What is the correct way to bill for no med pay or maxed benefits because they really aren't conditional payments?

Colorado Health-OP

- How they differ from other health plans. What is so unique with their model/program. Why would members prefer to sign up with them? What kind of provider network are they using?

RMHP –

- Understanding is that Cover Colorado and Getting us Covered have gone or will be going away, is this accurate?

Payers – NO Specific Questions For :

Colorado Workers Comp Division/Dept.

Humana