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Private Payers Make More Policy Changes Outside Provider Contracts

By Nina Youngstrom

Starting Oct. 1, Anthem Blue Cross is increasing the penalty for hospitals that miss the notice deadline for emergency admissions. Hospitals that fail to inform the commercial insurer of emergency admissions by a deadline set forth in their manuals will lose 50% of their reimbursement, according to a change in its policy.

That's the latest example of payment policy changes that commercial payers and Medicare Advantage plans are using to drive down payment rates to hospitals without modifying their contracts, according to attorneys and physician advisors. UnitedHealthcare also just announced its "site of service" policy for outpatient surgeries covered by commercial plans. Effective Sept. 1, United said it's conducting medical necessity reviews to determine whether procedures should be performed in hospital outpatient departments, noting that UnitedHealthcare members "may choose" to have procedures at ambulatory surgery centers (ASCs) or elsewhere. Physician advisers also report they are struggling with Medicare Advantage (MA) plans that authorize observation stays instead of inpatient admissions without acknowledging they are denials, and because they don't technically deny the admission—they unilaterally change it to observation—hospitals may have a hard time getting paid for medically necessary admissions ("Some Payers Approve Observation Over Admission Without Denials; Arbitration May Help," *RMC* 27, no. 21).

Some Hospitals Don't Contract Anymore

"What health plans are doing now is looking for ways to reduce payments to providers. Rather than change contracts, they change policies, which has the effect of changing contract terms," says attorney Daron Tooch, with King & Spalding in Los Angeles. "They have been doing this for a number of years in a number of different areas. This is the latest version of it."

Some MA plans tell physician offices that preauthorization isn't necessary for procedures that are performed on an outpatient basis. That way, the physicians won't order inpatient admission, says Bradley Bryan, M.D., medical director of regional utilization management & clinical documentation improvement at Providence St. Joseph Health in Portland, Oregon. But sometimes the patients wind up requiring three or four days in the hospital. "The MA plans say, 'We authorized it as outpatient, so that's what we'll pay,'" he says, even when inpatient admissions are medically necessary. "They use tactics that lower their payment responsibilities," Bryan contends.

Some MA plans also delay authorizations for skilled nursing facilities (SNFs), which turns the hospital stay into custodial care, physician advisors say. "We are stuck sitting with near 100% capacity waiting for MA plans to authorize stays," Bryan says. A few MA plans have automated processes to approve post-acute care, but they give the authorizations to SNFs, not hospitals. That upsets the SNFs, which want written authorizations, not "auto auths," he says. "It creates a bit of uncertainty with our post-acute care partners," who have doubts they'll be reimbursed by the MA plans for the admissions. Because of the delays, MA plans squeeze two extra days of hospital care for patients for the same DRG payment, he explains.

There's only so much that hospitals can do to fight back, although appealing on behalf of the patients is an option with MA plans. For commercial plans, Tooch says they can try to change the contracts, but some hospitals are dropping commercial plans altogether.

"I represent a county hospital that refuses to contract with any payers except Blue Shield because their patients are insured under Blue Shield," Tooch says. Commercial payers are required to pay for emergency room (ER) care at all hospitals, regardless of whether they are contracted, and this hospital, located near a ski resort, has heavy ER traffic.