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Specialties: Payer Analysis, Managed Care Negotiations, Design and Implementation of Financial Systems, Physician Practice Start-Ups, Strategic Planning and Financial Management. Dana is responsible for related managed care activities throughout multiple provider networks and affiliated IPA's. The CodeToolz Contract Analyzer's primary focus is to provide precisely timed, data-driven payer renegotiations, securing the best payer fee schedules possible.

Payer Contracts and Negotiations

What kind of an increase can I expect?

Successfully renegotiating your insurance contracts typically yields a 10-12% increase over a 1 to 3-year period. This is money that is available to nearly every office but is lost because most offices do not have the time or expertise required to successfully renegotiate their payer contracts. If you do not remember the last time your contracts were negotiated, then this a service that you cannot afford to pass up.

Should I negotiate my insurance contracts?

Most insurance companies will only provide you with the increase that is due for the current year (2-5%). If you want more, you need to have the tools that will illuminate the added value your organization provides to their members. Remember that you are providing a valuable service to their organization and it is important that you remind them of this often-forgotten fact. Considering the Affordable Care Act and the increased competition among insurance companies, everyone is scrambling to provide more value and service to their members. The value they are most often "finding" is through cutting reimbursements for providers and reducing the member's premium expense. Every penny really does matter to the payers now that customers could evaluate plan options and price through the exchange. You must be the physician that they do not want to lose, how you show them this will require some skill.

Gathering Current Contracts and Fee Schedules

This is dependent on what you have on hand and how responsive your Payer Representative is. This information must be gathered. This is by far the most time consuming of the entire process.

Average Timeframe to Negotiate Insurance Contracts - 150 Days

30-60 days for the payer to acknowledge receipt of request to negotiate and respond to initial request. Remember that you need to evaluate your current contract before attempting to negotiate. You need to follow the negotiation process outlined in the Agreement.

60-90 days to receive the initial proposal back from the payer. Depending on how responsive the payer representative is, it will probably take 4-6 weeks for each subsequent rate proposal.

90-150 days to finalize the rate negotiations and receive the take it or leave it proposal from the payer. Payers love to drag out the negotiation process so it's important that you stay persistent with your payer representative.

This is only an estimate. Develop a good relationship with your payer representative as this will help move things along during the negotiation process.

It should be noted that it can take much longer to negotiate some agreements. It really depends on the payer, where you're located and your specialty. It's not unusual for it to take 8-12 months to negotiate some agreements. The more complex your organization (multiple lines of business or ancillary services) the longer it will take to negotiate. You must consider how each proposal will affect each business unit and the organization.

Strategies for Negotiating Insurance Contracts

CodeToolz offers physicians managed care contract negotiation services that employ proven contracting strategies, years of experience and the most advanced tools available. Our professional team develops a personalized contracting strategy for every client that fits their unique practice and objectives. Successfully negotiating a contract does not happen overnight but the outcome is typically very rewarding.

Step 1: Development of Contracting Strategy

Our strategy is derived from decades of successfully negotiating contracts from the physician and payer side. Our experience is from both sides of the equation which gives us unique insight into what the payers are looking for and need out of their physician contracts. The strategy employed for each group will be different but some common elements are: the identification of key payers to contract and/or renegotiate with, evaluation of the physician environment to identify future contracting opportunities and pitfalls, determine current market rates with other payers, identification of group's core competencies, evaluation of competition and how it helps or hurts our position, and the highlighting of potential cost savings and outcome based strategies to present to insurance company.

Step 2: Evaluation of Current Managed Care Contracts and Fee Schedules

This is a critical part of the process as it provides us with the insight needed to develop a succinct strategy for renegotiation. We use our CodeToolz Contract Analyzer to do this. We then compare the payer's fee schedule to current year Medicare and set our goals as to what we expect as a result of our negotiations.

Step 3: Contract Renegotiation and Consulting

We assess each contract and determine if it meets the contracting requirements of client. We also ensure that the rate they claimed to give is what is present in the contract. Once the renegotiation process is nearing completion, we will recommend a percentage of Medicare that should be billed out. This is usually between 150%-200% depending on insurance rates. Some contracts will pay a percentage of billed charges (although this is rare) so it is important to have your charges at an adequate level to capture all potential revenue.

Timeframe for Completion

The timeframe for the completion varies by area and the cooperation of both the insurance companies and respective client. Typically, clients can expect anywhere from ninety days to six months. Constant dialogue is needed between client and CodeToolz for the contract negotiations to be successful.

Considerations During the Prenegotiation Phase

These questions (but not limited to) should be incorporated into your Contract Renegotiation Notice. It would be a mistake to simply state “you want more”, you must make your case and they must be sent to the proper person. This person is the one identified in your Source Document and Contract Analyzer (Rep. Contact Info).

- If true, it should be stated that you have not had an increase to your reimbursements in (x years).
- What separates you from your competition?
- What do you do clinically better than your competitors?
- What benefits do you bring to the hospitals you cover?
- What are benefits to the patients you treat; in your opinion, what is the level of patient satisfaction?
- What do you do clinically that reduces healthcare costs for the payer?
- What about you makes you “special” within the payer’s provider network?

Evaluating Your Payer Contracts is Essential

Payer contracts represent a significant amount of physician revenue and should be evaluated with scrutiny. Physicians who fail to gain a clear understanding of their payer contracts risk presenting a financial blow to their medical practice. Having a process in place to regularly review all the contracts in your organization’s portfolio is a must.

Transparency

Payer dashboards are the right source to contextualize data, enhance clarity and put stress on KPIs along with promoting transparency in a payer fee schedule.

Quick & Easy Access

They help segment, summarize, and visualize reimbursement data to help us understand what's essential and what contracts require attention. Providers can interact with their payer data through the

dashboard to make quick analyses and act with purpose. For example, payer dashboards can offer real-time analysis of a decrease in payer fee schedules.

Make Better Decisions

Payer dashboards are the foundation of the contract decision-making process. These interactive dashboards act as a decision assistance tool that helps you make a more informed and accurate decision driven by the data.

Prioritize Through Reliable Data

Another benefit of a payer dashboard is how they can showcase the most relevant and reliable data. The smartly rolled-up data into high-level goals can allow establishing priorities without a hassle. The payer contracting chaos may seem overwhelming, but it incorporates many potential opportunities. Payer dashboards can prove to be the best management tool to help you gain unexpected benefits that could be missed without the right perspective.

Are Your Payer Contracts the Reason for Declining Revenues?

We often find that the reason behind declining revenues doesn't have to be discovered – it's right there in plain sight in your payer contracts. While working with physicians across the country, we have seen payers reduce their fee schedules by 7 to 12%.

Payers accomplish this by terminating an older agreement, so that they may enter into a new provider agreement with less favorable reimbursement terms. Payers will send amendment notices to physician practices, indicating their desire to "integrate" which often indicates an intent to lower the fee schedule. The challenge is that providers may be given as little as 30 days to respond to these notices, with failure to respond constituting acceptance.

Evergreen Clauses

These clauses allow payers to renew contracts automatically if the existing agreement is not renegotiated within a specified time or upon expiration. So, if an expiration date slips by you, you will end up stuck with an outdated fee schedule that does not meet your practice's current financial needs.

With our Contract Analyzer no contract renewal date will slip by you. In fact, our renegotiation process starts 120 days before the renewal date.

The Importance of an Accurate Payer Matrix (Dashboard)

Too often we discover physician practices that not only don't have ready access to their payers' contracts but also do not have a payer matrix. A payer matrix essentially lists key data for each payer, including contact information, reimbursement terms and key provisions in the contract.

Payer Contract Re-Negotiations

Most offices have never renegotiated their contracts and very few renegotiate them on an annual basis. This simple fact means that practices are missing out on additional revenue that can be substantial and greatly impact the practice's revenue. To increase revenues, a medical practice must attempt to negotiate with its managed care payers. Without any attempt at negotiation, any practice will be at the mercy of any payer in its own service area. Practices can improve their revenues through an aggressive managed care payer contracting strategy.

Ensuring maximum reimbursement in a timely manner is always at the top of a healthcare provider's mind. But we find too often that many providers are leaving money on the table with inefficient and infrequent payer contract management.

Providers can overcome these challenges and maximize their revenue by creating a central space for contracts, analyzing financial terms and preparing for re-negotiations.

Understanding and Defining Your Leverage

The ability to negotiate or renegotiate a managed care contract is often determined by the amount of leverage a practice or provider has in the marketplace. To identify your negotiation leverage (or lack thereof) and opportunities for shared benefit, start with a SWOT analysis (strengths, weaknesses, opportunities, threats). Most physicians come to the negotiation table without a defined contract strategy.

- Do you perform unique procedures or services, are you highly trained, is there a shortage in your market, etc.?
- What are benefits to the patients you treat; in your opinion, what is the level of patient satisfaction?
- What do you do clinically that reduces healthcare costs for the payer?
- What separates you from your competition?
- What do you do clinically better than your competitors?
- What benefits do you bring to the hospitals you cover?
- What about you makes you “special” within the payer’s provider network?

The practice may provide expensive, unique equipment that will not be available to patients if the practice does not participate with the payer.

The success of renegotiation rests on the ability to provide cost-effective, evidenced-based services and convince payers of their value! The goal is to tell a story about the practice and communicate why a raise in rates should be granted. If true, emphasize the fact that there has not been an increase in years. Your purpose is to convince the payer that you offer superior service, above and beyond what other competitors offer.

Pre-Negotiation

Before you begin the negotiation process, you must decide on the important issues that you want to negotiate. There are two main issues involved with any managed care contract negotiation:

1. Negotiation of financial terms, and

2. Negotiation of legal terms.

It should be no surprise that financial terms are critical factors to physicians since they have a direct impact on revenues. For legal terms it may not be so straightforward. The objective is to try to negotiate into a contract with legal terms like the ones included in the American Medical Association's model agreement.

To most providers, the most important part of any contract is the fee schedule. If the fee schedule is unacceptable, the clauses and language contained in the rest of the contract is irrelevant.

Writing Notice to Renegotiate

- On letterhead with practice name, TIN and locations.
- List all physicians and signatures within the practice.
- Prepare a value proposition / proposal letter and get it to the payer contracting manager.
- Date by which you request a response.

Initial Payer Responses

You can expect most payers' initial response to inform you of a moratorium on negotiation or a "we're already paying market value" message. Don't accept that. Tell them that's not in the contract.

If the payer is not willing to publish the fees it pays other practices, its claims about market value to other practices will be unsubstantiated and meaningless to your negotiation. This is why you have our Contract Analyzer - to truly determine what other payers are paying in your market.

Re-Negotiation Appeals

You may want to consider the following language in response.

> "According to the terms of our agreement, I can serve you notice at this time. Please know that the purpose is to renegotiate and not terminate, but if we don't come to terms in 30 days, please understand that this is my termination notice."

Payers may say they don't renegotiate under threat of termination, but there's no sanction without the threat and the payer can simply disregard your notice to renegotiate.

Warning shots fired in the form of a termination notice may be needed to begin the process. Why? Friendly requests for term renegotiations can be fruitless if the payer believes you will not terminate the contract.

Ask yourself this very real question: are you willing to walk out on the contract and terminate if the network or payer won't work with your terms? Be firm on the terms you want. It's up to you to decide what to accept.

If the practice anticipates that the payer will not cooperate in improving contract terms, the practice may preemptively make this known to referring physicians, facilities where the practice provides coverage, to employers and to patients. These groups may intervene on behalf of the practice.

Creating an Effective Payer Proposition Letter

Your CodeToolz Contract Analyzer provides the kinds of data you need prior to negotiating reimbursement rates with payers. Now it is time to put this information to work by preparing a simple but substantive proposal letter that is sent to the payers' contracts manager that introduces the practice, the request for a rate increase and, most importantly, the reasons for the proposed increase.

An effective letter is no more than one to 1½ pages long. Remember that this letter is a sales pitch and attention getter, written from the perspective of payers explaining to the latter why they should increase your reimbursement. Payers need a good reason to give you more money.

One of the most common mistakes when conveying a value proposition is that it is often too long and often focused on patient benefits rather than payer benefits. Fundamentally, payers care about two things in evaluating the inclusion of providers into their networks or possible rate increases.

First, will this provider's efficiencies save money and, secondly, does this provider demonstrate a higher quality of care and better clinical outcomes when compared to competitors in the same field? Related to these items, as well, is the perception that the payer is concerned about the wellbeing of its beneficiaries.

Payers are health insurance companies and they are in business to maximize the intake on its premiums while minimizing its risks / payouts. Bringing providers into its network that are efficient and focused on extraordinary patient care enables the payer to meet its key business objectives.

When preparing value propositions, you can focus on any combination of service benefits, product benefits, geographic coverage, referrals from hospital systems and large practices, and treatment / clinical benefits.

Let's explore some focused value propositions that will likely lead to successful payer contracting outcomes. To get payers' attention, consider the following structure of the letter:

Start with the name of your practice, your book of business with the payer and the number of patients or cases you treat per year. The adage that "money talks" could not be more apropos here. Practices with large books of business and large patient loads have leverage. Payers want to maintain practices in their networks that keep their patients and large employer groups happy. This is where the payers get their business. To the payer, their most important customer is usually the large employer who brings in big premium dollars that can be invested to generate more profits.

Next, talk about your geographic advantage, if there is one. For example, if you are the only full-service (your specialty) practice between Phoenix and Tucson, you have leverage. Payers will need to meet individual state licensure requirements to have a certain amount of specialty physician coverage within a specific geographical radius. It could be critical to a payer's coverage strategy to have you in its network. Talk about your specialties and qualifications but be careful not to go overboard. We all are passionate about what we do and why we are deserving of recognition. In one to two paragraphs at most, describe the qualifications and specialties of your practice and what makes you different and unique from your competition if you have any.

What we don't want to do is only talk about how we provide compassionate care and take extra time with patients. While this is great for patients, it does not help a payer understand why it is good for the payer to have this provider in its network or to consider this provider for increased reimbursement rates. "Ask not what the payer can do for you but what you can do for the payer."

Explain that you cannot keep treating their patients at the current contracted reimbursement. Specifically, state that you have analyzed your current reimbursement levels and have determined that the rates in your current agreement are not competitive with your other payer agreements and you are losing money on many of the procedures you perform. As such, you have attached the following as a proposal for reimbursement.

Provide a clear list of items that you are seeking. Keep it short. Depending on the structure of your agreement and your analysis, you may state that you are asking for an xxx% increase in Payer X's current fee schedule for all your codes. Or, you may state that you are asking for xxx% of local Medicare rates for the following 40 codes, which represent your highest volume and highest priced procedures. You may also want to carve out high volume/priced ancillary and surgical codes since many payer agreements either pay these at substantially lower rates or no rate at all.

Remember to place a timetable when you expect to hear back. For example, "thank you for considering this proposal and we are expecting a reply back no later than XX/XX/XX. Three weeks is a good rule of thumb. Make sure the letter is directed to the correct person and department in a payer's organization.

Summary

The proposal letter is the first correspondence with the payer which communicates your request for an increase and the reasons. Payers are business entities focused on generating profit. Many are publicly held corporations which trade stock. They need to understand the business value of why your practice needs more money and why they should give you that money to keep you in their network.

Value propositions are built around the business areas that a payer focuses on such as cost savings, treatment benefits and enhancing the payer's image and perception as a health insurance company that cares about its beneficiaries.

Closed or Narrow Payer Networks

Let's begin with answering the question "What is a closed or narrow network?" A closed network is a payer network which currently has participating (par) providers like you and, therefore, is not adding

more similar providers, including you, to their network. A narrow network means it has enough par providers of a certain type and are generally not looking to expand further. Since many payer networks are already complete, it is often challenging for providers to get contracted.
This challenge is especially prevalent for independent and small practices. Therefore, the question is what can you do as a provider of valuable medical services and or products to get into a closed or narrow payer network?

Step 1 - Value Proposition

Prepare a value proposition / proposal letter and get it to the payer contracting manager (not the provider relations representative). If you write a strong enough value proposition the payer just may say yes and you are contracted. If you receive a no, then go to Step 2.

Step 2 - Responding to Objections

Often the objections will be centered on the fact that there are already several providers in a payer's network fulfilling the networks requirements for your services. See if you can find out who the par providers are and what your competitive benefits are versus those already in network. Realistically, if you are turned down to be a par provider, you will need to demonstrate specific service advantages compared to those already in the payers' network.

1. Payers tend to look for three reasons to add a provider to a closed or narrow network:
2. Cost savings and efficiency / treatment benefits.
3. Service advantages leading to higher patient satisfaction.
4. PR benefits - will this provider help me demonstrate as a health insurance company that I care about the well-being and treatment benefits for my members? While you may not often think about payers focusing on the PR benefits of their provider networks, this is a very important objective, particularly for large national payers.

Step 3 - What to do if you still get turned down to be a par provider?

Often a first level contracts' manager or negotiator at a payer is given specific guidelines to follow in specific areas including narrow and closed networks. As such, no matter how strong your value proposition is, based on the advice in step 2, above, you still may get turned down. It may be necessary to get a meeting with the regional Director or VP of payer contracting to explain your value proposition directly. In other words, escalate your proposal up the chain of command.

There are payers that operate as specialty networks for large national payers. There are also many payers who operate as TPAs (Third Party Administrators) or ASOs (Administrative Services Organizations). These are companies that act as the agent for large employers and administer the health insurance plans for their employers. There are also "complementary payers and networks" and "single-case and continuous-case discounts". These are saved for another discussion.

In summary, when applying to a closed or narrow network, remember to follow the steps outlined above, methodically. Focus on the combination of the extra value you bring to the table compared to competitors who may already be in the payer's network.

Single - Case and Continuous Case Agreements

A continuous-discount arrangement (CDA) creates an on-going contractual relationship between the provider and a noncontract payer or repricer and saves both parties from negotiating a discount each time the provider sees a plan member out of network. If you treat plan members out of network, a repricer (or other agent of a payer) may have already asked you to sign an agreement that gives the repricer a set discount off your billed charges on an ongoing basis.

Typically, a CDA sounds like a plan contract, but it is not – it is not made with a plan and does not involve the typical contract requirements. It may be totally enforceable may ultimately be unilaterally beneficial to the repricer, and not to the patient. There is often no requirement to participate in quality assurance, credentialing, or similar obligation. Repricers are after a relationship that is strictly financial, and discount driven. Since they are not the payer, they are simply negotiating the rate, and not the fact that you might not ever actually receive the payment. That is not their issue. Their deliverable is completed

when they lock in the provider for a set price, upon which they often receive a commission as a part of the savings.

Although repricers have typically asked for a one-time discount, also referred to as a single-case agreement (SDA) for a plan member treated out of network, more repricers are offering an ongoing discount agreement, which is called a CDA. Providers need to be very careful with these documents because they may seem innocent enough, they can have far-reaching implications into your revenues and your sanity.

Keep in mind as a noncontracted provider, you are owed timely payment per insurance statutes and/or administrative codes; you have no contracted obligation to provide a discount on your out of network services to a plan member; you may have a valid assignment (check with your attorney, as each state's laws may differ); and you are under no obligation to provide a discount on future services from that repricer.

Assuming there are no reasons not to sign the deal, it may be financially worthwhile for you and may help you avoid the administrative hassle of regularly negotiating discounts with the repricer for plan members who you treat out of network. The problem is that this is often a huge assumption that requires tight control and detailed knowledge of all your other contracts, as well as contracting policies that include a stance that you have no contracts that may have a "most-favored nations" (MFN) or preferential rate that requires that, if you give someone a better a rate, even just once, you have to lower the MFN payer too.

In many cases, the revenue management department or physician practice manager receives a call asking for the discount and is then asked to memorialize the oral agreement with a fax memo that documents the rate which has been agreed upon. Some are only one or two sentences and ask the provider to sign in a designated space. Sometimes it makes mention that this agreement applies to future encounters with this or another patient from the same plan; sometimes it is mute to that fact. A problem arises in administration of this deal in that, in order to post the payment, revenue or posting code must be entered for that payer and for the adjustment. Once that is in the system, it may be misinterpreted or mishandled by admitting staff who verify whether the payer is in the system at the

time of admission or scheduling. If so, the presence of a code may lead that registrar to assume that there is a contract and that precertification's and so forth, are required, and that other familiar managed care policies and procedures are applicable.

On the reimbursement end of the revenue cycle, assumptions may be made about writ-offs, late payment penalties, medical records copy fees and the like. Silent PPO cannot be argued, as the discount is memorialized in writing, even if it is memorialized by someone with no authority to bind the provider. This little memo could cost you much more than the discount, and the risks may not outweigh the benefit of a quick spot negotiation.

While some argue that CDA's will increase a provider's business, this is difficult to prove. Since the repricers deal only comes into play when an out of network charge is incurred, one could argue that there is no steerage. While it could, in some circumstances, potentially increase your business, it is nearly impossible to track.

It may increase your administrative hassle factor because, as stated previously, the negotiation is only for the rate, not the performance, of actual payment or accurate payment in a timely manner. While it may save you time on future negotiations, one could argue the merits of being selective on the execution of CDA's, keeping their number to a minimum, and requiring full payment for all others who bring no value-added proposition to the deal.

Those repricers and others in favor of CDA's often argue by intimidation, stating the patients will get paid, or that your staff will be inundated with faxes asking for discounts. I have never seen the situation of a "mountain" of faxes awaiting consideration. It may also be difficult to sort out if you already have an executed CDA with a repricer, and they may often negotiate higher and higher and higher discounts, If there is no restriction as to the ability to assign the discount, they could infect your other higher-paying CDA's and contract by selling access to their price with you.

Typically, repricers ask for generous discounts of 10% to 30% off the providers billed charges in a CDA. Do not be afraid to negotiate smaller discounts if there is nothing in the deal that would be mutually beneficial to you. Remember, they will likely make a commission off each claim that is paid at the

discounted amount. The value to them is in the frequency, and every dollar after the first deal is just passive income.

Every contract should have 5 basic elements: (1) an identification of the parties, (2) an effective date, (3) an agreement to the obligations of the parties, (4) a discussion of the money to be paid, and (5) a termination date and method by which the deal is terminated. Since these two-sentence faxes may be missing a few of these elements, they may not have a way for you to shut them down if you need to. They should also have contained in them a restriction on the ability to assign them to others without your express written consent.

If you choose to execute CDA's as part of your business model, you may wish to have your attorney draw up your own CDA that has the required protections for you, instead of signing the form of each repricer. Ensure that your attorney addresses the fact that, if the patient is found to be a member of a different network through some other arrangement or contract, then the discount will not apply, and you will be entitled to the higher of the rates. Also, have the attorney include some provision for timely and accurate payment and that, if the account is not paid in full by a certain date, the discount is rescinded and the full amount due.

Finally, have the attorney mention in the document that they may not interfere with your financial relationship with the patient with things like balance billing, compensation for noncovered or nonallowed services, medical necessity denials, and so forth.

As with the CDA, the same admonitions apply to the single-case agreement (SCA). Here the form should have the necessary protections for you but should also designate that the agreement is case specific, episode specific, and for a specified patient for a specified service, admission, test, or episode of care. It should always have an expiration date and should include in it, just for the record, that it is one-time use only.

If they cannot agree to the terms you need, you probably do not need their discount. Remember, they clearly have little to no leverage with you.