Payer Contracting- Assessment & Renegotiation Process Overview

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Learning Objectives

• Gather payer agreements, amendments and fee schedules
• Determine When/How agreements can be negotiated
• Analyze/Compare payers’ schedules
• Develop/Roll out renegotiation strategy
Goal for this session

• Building the FOUNDATION for your Daunting Payer Contracting Renegotiation Project... to improve the bottom line and manage the process going forward.
  • No more excuses!
  • Take Charge!
  • You can do this!
  • And you can do it right!

What We’ll Cover to Get There

• Gather your current contracts/addenda and rates
  • Inventory the contracts
  • Inventory the rates
• Gather Utilization Data to use in Analysis
• Examples of Comparative Analysis & Offer/Counter Impact
• Determine WHICH contracts need tackling and WHEN contractually possible to renegotiate
• Initiate the Renegotiations Properly
• Determine and Manage timelines –
  • notices
  • terminations
  • effective dates
• Few Tips to Tackle Unexpected Obstacles
• Hone in on Allergy & Asthma specific nuances in negotiations
Before we delve in... few important NOTES

- CPT is the trademark of the American Medical Association (AMA) and may be referenced on several pages of this presentation
- Discouraging Process: Perseverance Needed
- Getting started on a payer contracting project is frustrating. Expect it to take:
  - ~ 2 months just to gather info covered in this session if you are diligent
  - ~ A year to complete your first few re-negotiations and
  - ~ 2 years to feel you have a solid handle on most/all
- Then plan on maintenance

Gathering Your Contracts, Rates and Utilization

- Find all of your current FULLY EXECUTED (Both Practice and Payer/Network signed) agreements filed at the office
- Find all the Addenda/Amendments between original effective date and present
- If you cannot find, don’t be embarrassed... you are in the majority and can blame the manager before you.
- Request from payer or network
  - Each payer has its unique means of requesting copies of agreements and fee schedules...everchanging
  - Ask Rep
  - Portals
  - Fax #s or Email Address
  - 800 Request lines
What Payers/Networks to Include In Contract and Schedule Gather Stages

- Commercial (BCBS, Aetna, UHC, Cigna, Humana, etc.)
- Government (No contract for Mcr and Mcd, per se, but get Fee Schedules)
  - Medicare
  - Medicaid
  - Tricare – HealthNet = West AND Humana Military = East
  - VA – tend to be at 100% Natl Mcr
- Government Replacement
  - Medicare Advantage Organizations (MAO) – Differ from Supplements
  - Medicaid Managed Care Organizations (MCO)
- Workers Comp/Auto – if rarely see, consider excluding from contracts
  - Find state FS if appropriate for your specialty and if one applies – few states based on UCR
- Networks – rented by payers and TPAs – ex: Multiplan and TRPN

Can you negotiate with Tricare Contractors or Medicare/Medicaid MAOs and MCOs? YES

- Tricare:
  - Tricare Max Allowable essentially = Mcr rates
  - % discount is not required by Dept of Defense but DOD contractors
  - HealthNet (WEST) & Humana Military (EAST)) often require 10% to 25% discount
  - Usual Language in Rate Exhibit: “Lesser of” % of Max Allowed or % of Billed Charges
    - Example: Lesser of 75% Max Allowed or 80% Billed Charges
- Medicare Advantage MAOs:
  - CMS does not require rates be same as Mcr
  - Plans can cover services not covered by Mcr
  - Sequestration reduction of 2% not necessarily implied in MA contracts – See CMS May 2013 Memorandum & Covid Guidelines & $1.9 trillion bailout w additional 4% sequestration
- Medicaid MCOs: Administered by states with significant variation by state
  - Most states have Mcd fee schedule and MCOs offer % of these – most at 100% Mcd, but not all
  - Some states like TN do not have Mcd FS where MCOs offer % Mcr
  - If you’re OON, some states protect MCOs… Ex: 95% of Mcd max
Inventory Your Agreements
Distinguish Individual vs Group and Direct vs IPA/PHO

Finding Your Current Rates
While there are lots of sources...
... Easier said than done

- Vague Contract Exhibits referring to undefined standard market schedules and not always clear re to which products rates apply
- Rates change over the years due to amendment and proprietary market schedules or CY Mcr based schedules
  - Jcodes/Injectibles can often be changed anytime w no notice required
- Special Fax and Email queries
- Web Portals – becoming MOST COMMON way to find rates
- EOB Allowables – NOT most reliable way to determine contract rates
- Request population of CPT* list by rep – ideal if they will do it
  - Always verify the $ amounts provided against any formula in the contract
Create a List of All CPT Codes Performed Annually with Modifiers and Fac/Non-Fac columns

- Create MS Excel Spreadsheet with ALL Practice Codes with Modifier and Place of Service (Facility or Non-Facility) for each product (HMO, PPO, Med Adv, Exchange, Medicaid, etc)

<table>
<thead>
<tr>
<th>CPT</th>
<th>Mod</th>
<th>HMO Fac</th>
<th>HMO Non Fac</th>
<th>PPO Fac</th>
<th>PPO Non Fac</th>
<th>Med Adv Fac</th>
<th>Med Adv Non Fac</th>
</tr>
</thead>
</table>

If primary care or office based specialty Non-Fac only; if surgical specialty Fac and Non-Fac needed

- Send to rep to populate the dollar amount of your current reimbursement by product
- Typical responses:
  - Rep populates sometimes or limits to top/sample codes
  - Rep sends FULL fee schedule for you to cull your CPTs
  - Rep sends you to a web-portal/email/fax #
  - If payer rates on portal, pull $ amounts for ALL Codes in practice utilization & by product (HMO/PPO ETC)

Sometimes Portal is missing labs, jcodes and other codes so ask rep to fill in these gaps

Web Portals for Rates Reliable but...

- Payer specific portal or NaviNet/Availity with ID/PW
  - Often portal is not “enabled” for FS lookup – get FS lookup enabled
  - Numerous product/plan names that do not match contract plan names, ugh! – which apply?
  - Unclear if contractual percentage has been applied
  - Limit the # codes you can retrieve at one time to 10 or 20... tedious cut and paste
  - Often labs and/or injectables are limited or not there
Find Medicare & Contract Values for All Codes include Lab, Supplies & Injectables
Understand Doses & Know Costs

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>HCPCS Code</th>
<th>Control Limit</th>
<th>Vaccine AVP%</th>
<th>Vaccine Limit</th>
<th>Blood AVP%</th>
<th>Blood Limit</th>
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<td>1 00025_1</td>
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<td>35575</td>
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<td>00035_1</td>
<td>3 00035_1</td>
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<td>1.00</td>
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<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Note 1: Payment allowance limits subject to the ASP methodology are based on 4Q19 ASP data.
Note 2: The absence or presence of a HCPCS code and the payment allowance limits in this table indicate whether Medicare covers a drug. These determinations shall be made by the local NCCI contractor processing the claim.

2020 Clinical Diagnostic Laboratory Fee Schedule

CMS Links to find Physician Fee Schedule + Injectables, Labs, DME/Supplies

- Physician Medicare Fee Schedule
  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched

- Injectables and Immunizations- Medicare Part B Drug Average Sale Price (ASP)
  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index

- Labs- Clinical Laboratory Fee Schedule (CLAB)
  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/CLinicalLabFeeSched/CLinical-Laboratory-Fee-Schedule-Files

- Supplies- Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule (DMEPOS)
  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule
You think you know your rates but Rates Change – How can this happen?
Two primary ways...

- Amendment provisions often allow the payer or network to modify the rates without the written consent of the provider
  - Sometimes notice is required but silence = acceptance
  - Sometimes no notice is required at all, especially on Payment Policy Changes (i.e. 25 modifier) and Injectables
  - Sometimes a fixed hardcopy list of codes are sent with new rates
    - Need to find codes your practice performs, find old rate and compare to new
    - Might impact few affected high volume codes, like admin codes for allergy shots

- Rates are tied to a payer’s proprietary Market or Standard Fee Schedule or payer’s RBRVS “based on” Medicare RBRVS or Medicare payable amount.

- As the payer decides to modify its proprietary market schedule in your market, your practice has essentially agreed to accept that modification without signature, sometimes no notice required, especially for injectables.

- Therefore, make sure you have updated the rates very recently and if assigned to staff, verify with from where and when exactly the schedules were pulled and to what products they apply.

Take Your TOTAL Annual Utilization Data from PMS for ALL PAYERS

- Select a recent but mature one-year period
- ALL billed codes and new codes should be addressed
- Include CPT, Mod, Payments, Charges, Place of Service (Facility/Non-Facility)
- Include data field that delineates payer and product (HMO, PPO, Med Adv, Exchange, etc) if possible. If not collecting now, start collecting by product for better data in future.

and Marry it with your rates
Run a 12 Month Utilization Report
with **ALL** CPT Codes Non-Facility (Office); Facility (Hosp/ASC) if applicable
Total All Payers A MUST; Payer Specific Helpful though
- Consider how Covid impacted utilization period-

At this Stage, Stop and Evaluate Charges
Why?

- All too often, practices have certain codes that fall below contract rates and almost all contracts have “lesser of charges or contract rate” provision
- Contracts that are primarily based on a percent off of charges will be devastating if ...
  - *Example: Charges are at 150% of CY Mcr and the agreement pays 50% of charges – you are agreeing to get paid 75% of CY Mcr.*
  - Many agreements default to a very low % of charges if no value for a specific code is in payer FS
  - ...default often at 35 to 50% of billed charges

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**JULY 23-24, 2021**
Create a Side-By-Side Line Up of all your Payers’ and Medicare Rates
Best to Include Charges, Max Allowable and Utilization too

### The Business Side of Healthcare

<table>
<thead>
<tr>
<th>Code</th>
<th>Code</th>
<th>Facility</th>
<th>Medicare</th>
<th>Non-Facility</th>
<th>Facility</th>
<th>Medicare</th>
<th>Non-Facility</th>
<th>Utilization %</th>
<th>% of Medicare</th>
<th>% of Non-Facility</th>
<th>Delta</th>
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<td>0.19</td>
<td>0.18</td>
<td>0.18</td>
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<tr>
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<td>0030</td>
<td>Laboratory fee</td>
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<td>0.21</td>
<td>0.21</td>
<td>0.20</td>
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<td>0.23</td>
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<td>0.25</td>
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<td>0.23</td>
<td>0.22</td>
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<tr>
<td>0060</td>
<td>0060</td>
<td>Emergency room</td>
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<td>0.28</td>
<td>0.27</td>
<td>0.27</td>
<td>0.26</td>
<td>0.26</td>
<td>0.25</td>
<td>0.25</td>
<td>0.24</td>
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**Now Let’s Determine Who’s Robbing You Most**

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<td>0.26</td>
<td>0.25</td>
<td>0.25</td>
<td>0.24</td>
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</table>
Calculating the “What If” Comparison

what if total utilization is multiplied by each payer’s utilization

If Missing Rates for Any Payers – Exclude Code

- Having a $0 value for any payer for a code can inappropriately imply the payer pays $0, and the amount might just be missing and not $0, thus incorrectly understating that payer's aggregate fee schedule value in the comparison

- If little-to-no utilization of code, don’t sweat it.

- If highly utilized code or a high reimbursement amount code, be diligent in asking rep for the code if not in portal

- If issue is a new replacement code, replace old code in the data with the new code using old code utilization

- Be cognizant that just because there is a rate in a schedule it does not mean it is a covered service
### Roll Up Total ALL PAYER Utilization X Each Payer’s FS

<table>
<thead>
<tr>
<th></th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>100% of 2020 MCR</th>
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<tr>
<td>C</td>
<td>Payer 1</td>
<td>Payer 2</td>
<td>Payer 3</td>
<td>Payer 4</td>
<td>Payer 5</td>
<td>Payer 6</td>
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<td>Radiology</td>
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<td>$557,985</td>
<td>$524,506</td>
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<td>$814,658</td>
<td>$792,339</td>
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<td>Lab</td>
<td>$133</td>
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<td>$92</td>
<td>$141</td>
<td>$143</td>
<td>$139</td>
<td>$98</td>
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<tr>
<td>Medicine</td>
<td>$6,083</td>
<td>$4,472</td>
<td>$4,204</td>
<td>$6,440</td>
<td>$6,530</td>
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<tr>
<td>Injectables</td>
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<td>$240,248</td>
<td>$225,833</td>
<td>$345,958</td>
<td>$350,763</td>
<td>$341,153</td>
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<tr>
<td>DME</td>
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<td>$464,783</td>
<td>$436,896</td>
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<td>$5,144,008</td>
<td>$3,782,359</td>
<td>$3,555,417</td>
<td>$5,446,596</td>
<td>$5,522,244</td>
<td>$5,370,949</td>
<td>$3,782,359</td>
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### Payer Fee Schedule Comparison – Non Facility

All CPT Bands – What If Total Utilization X Each Payer FS

![Chart showing Total NF Utilization for CPT Codes Included in Analysis](chart.png)
Payer Fee Schedule Comparison – Facility
All CPT Bands – What If Total Utilization X Each Payer FS

Total FAC Utilization for CPT Codes Included in Analysis

Evaluation and Management NF – What If

E&M
Do “What If” Analysis for All Major Bands as well ....

- E&M
- Surgical
- Medicine
- Lab
- Radiology
- Injectable Challenges – especially JCodes and Immunizations
- Sometimes use Specialty Band Subset – Examples:
  - Peds- subset analysis Preventive Visits, Immunization Admin
  - Derm – subset analysis of dermatopathology or Mohs
  - Rad – subset analysis of high tech MRI and CT
  - Oncology/Urology – Cull Radiation treatment out of rad band

<table>
<thead>
<tr>
<th></th>
<th>Payer 3 Current</th>
<th>Payer 3 Proposal on 8/1/2020</th>
<th>Practice Counter on 8/15/2020</th>
<th>Payer 3 Counter Y1 on 10/15/20</th>
<th>Payer 3 Counter Y2 on 10/15/20</th>
<th>100% of 2020 MCR</th>
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<td>Surg</td>
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<td>$3,620,362</td>
<td>$2,924,138</td>
<td>$3,063,383</td>
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<tr>
<td>Rad</td>
<td>$284</td>
<td>$295</td>
<td>$499</td>
<td>$403</td>
<td>$422</td>
<td>$284</td>
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<tr>
<td>E&amp;M</td>
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<tr>
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<td>$3,697,718</td>
<td>$2,986,619</td>
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<td>$2,844,399</td>
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<tr>
<td>% of 2020 MCR</td>
<td>100%</td>
<td>103%</td>
<td>130%</td>
<td>105%</td>
<td>130%</td>
<td>100%</td>
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</table>
Use Your Contract Inventory Notice Dates and Comparative Line Up of Rates and Utilization to determine what to tackle and when

- Which payers’ rates need most attention
- Payer Mix – what % of business for each payer
- What date can you notify the payer or network
- Does contract allow off-anniversary notice
- Send notices to initial payers – don’t negotiate too many at one time – overwhelming
- Get concurrence of your physicians/managers
- Send notices

Term and Termination Provisions Set Timeline For Re-Negotiations – Know when you can go to the table
Getting the Notice and Negotiation Started

• Find notice terms and termination provisions – these drive when and how notice is to be sent

• Decide upon the payer or network with which to negotiate based on...
  1. notice dates and
  2. financial impact on practice of payer rates
     • both strength of schedule and % market share of payer

• You will be inclined to want to negotiate the whole darn bunch of them but generally don’t tackle more than two major negotiations at one time

Challenges and Tips Regarding Renegotiation Notice

• Know #days notice required and if tied to anniversary
• Rarely a “renegotiation” clause – Use Term and Termination provision as the driver
• If Individual vs Group Agreement - all providers sign
• Info to include covered later in session
• Send w signature receipt required and SAVE proof
• Plan to follow up – you drive the timeline
  • Without Termination Date on Table – Payer is rarely in any hurry
What if you ask nicely without term notice?

- Sometimes the payer will come to the table in good faith and negotiate without the threat of termination - rarely, but if paper is old they want to get a compliant agreement done too.
- Agreements lack a “re-negotiation” clause so often termination is the only contractual mechanism to use.
- Unfortunately, without term notice, there is no hurry on the payer’s or network’s part and so expect LONG delays in responses.
- If termination is tied to anniversary and you try w/out termination, and then get frustrated with the negotiation, you may have to wait a year to get tougher because you just missed the notice period.

Let’s write your notice to Renegotiate/Terminate Send w Proof of delivery to Contract Notice Address and to Rep

- Practice name
- Practice TIN, Group NPI and Locations
- Physicians and Mid-levels w Individual NPI
- If Individual Agreements – signature of each provider
- Intent to renegotiate but with termination date if terms not agreed upon by given date
- Date by which you request a response
- On Letterhead
- Keep the delivery receipt until negotiations are done
What if you are leaving IPA or PHO and Negotiating a Direct Agreement

- Send Directly to IPA/PHO but also to Payer advising you are leaving IPA/PHO and wish to go direct
- Review your IPA or PHO agreement to determine what notice to the IPA or PHO is required
- Remember that your credentialing may be “delegated” through the IPA/PHO and you will need to credential directly – ask payer about how to make this transition without a non-par gap.

Have a decent rep?

- There are some very professional reps out there – wish it was the majority
- Some Payers and Networks have gone to a no-assigned rep approach – generic email, phone, fax
- Give the rep a ring or email with a heads up to advise you are sending formal notice per the contract terms and advise you wanted to give a courtesy heads-up and not blind-side him/her.
Prepare List of Things That Sets You Apart for Negotiating Leverage – save these for later

- Primary Care – most markets have a shortage and members are very loyal to PCPs; Employers want happy employees
- Specialists – unique procedures, highly trained, shortage in market, certain govt plans require access to members, etc; Orthopedics prime to offer bundled payment program for joints
- Put yourself in their shoes – they want to keep costs down
  - Extended Hours – reduces payers’ cost for the very expensive ER visits
  - Willingness to hear what your practice can do to change utilization/referral patterns or facility use or improve their Members’ experience
  - Happy to consider performance based programs – most today are for PCPs
  - Payers are looking to keep their customers, mostly employers, happy
- Employers with which you have a very good working relationship – keep them informed

As you send notices....
Ask yourself this serious question

Are you ready to walk out on the contract and actually terminate if the network will not present the rates and terms that you require?

How Well Do You Play ??
Expected responses to your notice

• Due to reform we are not able to entertain any rate increases at this time. Our CEO needs to continue her $24mil base salary and if we give you an increase, she won’t meet her bonus goals.

• You are asking for a 23% increase all at one time – we can’t do that. It is not our fault that you did not complain the last ten years as we kept lowering your rates.

• We cannot provide an increase at this time but we can consider your eligibility for our P4P program that pays a pittance and it will be paid a year and a half after the period for which you are being reviewed

• THE CLASSIC _ You are at market schedule and other providers accept these rates - So What! So they haven’t evaluated their contract either?

None of these are reasonable – Respond with confidence

• We understand that your company would like to keep our rates at current schedules which are no longer sustainable for our practice....

• Cite concise value added info about your practice and state: ...I would like to prepare an offer for your consideration. Would it be best to base it on:
  o Current proprietary schedule or a particular year and locality of Medicare or
  o If Mcr, what year and locality
  o Carve-outs of highly utilized or specialty codes
  o Oh and...What would be the initial term of the new schedule?
Before We Wrap Up Today... Few Tips on unforeseen issues you will encounter

- Who has access to the agreements?
- How to prepare if you plan to walk (or bluff)
- How to manage the timeline if term date approaching
- State Laws that can impact negotiations or term
- What if you are in a CIN or contracted with a IPA or PHO

If You Do Walk...

- Ask payer if and when member letters will drop in the mail
  - Know your state’s law, if any, re member notices
- Request copy of Letter in advance from payer and list of members to whom they will send
- Notify Patients with your own notice – make it about the patient as much as possible
- Ask payer how Continuity of Care in your agreement and members certificate will be administered
  - Know your state’s law re Continuity of Care
- Educate Schedulers and Billing Staff
- Establish Policy if Payer direct pays to patients
- Educate Employers and Patients w/o sharing confidential info
If Negotiations Are Going OK But Need More Time

- If termination date is approaching and law or payer guidelines require member notices soon, put an extension on the table to postpone notices.
- Ask payer if email extension is adequate or does it need to be on letterhead
- Typically 15 to 30 day extension is adequate to wrap up; keeps all parties focused on new deadline
- Payers often ask practice to “rescind” vs extend – in most cases don’t take potential term off table, just extend deadline and/or term date

Research Your State Laws

These apply to insured plans but you can make them apply to self-funded

- Among laws that usually work for you in negotiations ...if they exist
  - Timely Payment
  - Timely Filing
  - Medical Necessity
  - Material Change/Amendment
  - Over/Underpayment and Offsets
  - Credentialing Timeframes
  - Any Willing Provider
  - Fee Schedule Disclosure
  - Assignment of Benefits upon Termination
State Laws Working Against you

• Among laws that can work AGAINST you in negotiations...if a law exist...and these do exist in most states...
  • Patient Hold Harmless*
  • Continuity of Care Upon Termination
  • Offsets

*Most states require reserves for HMOs and insured plans but DOL does not require reserves of self-funded plans. If insolvent the insured plan has funds to pay run out claims as the plan phases out.

Do you need to be in every network?

NO

Certain Specialties can survive more easily than others without payer and network agreements
In Conclusion... Initial Phase of Project

• Start by gathering your agreements/addenda and rates for all codes
• Use ALL codes and Weight by All Payer Utilization to compare fee schedules “apples to apples” – payer to payer and Medicare
• Know When and How to initiate a negotiation and manage the timeline using contractual terms
• Prepare and/or Manage... do it right!
  • Timelines – Notice to Payers, Term Dates, Member Notices
  • What Makes you Special from Payer perspective
  • State Laws
  • Ask Payer What Kind of Offer They Can Administer

Questions?

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