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On the topic:
Strategies for Successful Payer Contract Negotiations
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Strategies for Successful Payer Contract Negotiations

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Opening Thoughts

• Payer negotiations are not easy. Expect it to take time and effort on your part.
• Do your homework up front.
• Avoid taking adversarial positions (don’t be a jerk).
• Is this really something that needs a contract negotiation? Where are you in the relationship? Can it be handled by somebody else?
• Make sure there are no issues on your side (billing errors, etc.).
A Shifting Environment

- Increasing consolidation and integration
- Increasing emphasis on payment for quality and reducing FFS payments
- Increasing need for data systems and integration to support quality data

Understand Your Goals AND the Payer’s Goals

- Do you want to capture new populations?
- Does payer want to capture new populations?
- Do you want to minimize risk?
- Do you want to streamline the payment process?
- Does payer want to increase organization efficiencies?
- Short-term contract or long-term relationship?
- At what point do you walk away?
Consider your Strengths and Weaknesses

**Strengths**
- Practice location
- Patient base
- Specialty
- Clinical competence
- Patient satisfaction scores
- Quality outcomes data
- Comparisons to other practices’ data
- Cost reduction strategies

**Weaknesses**
- Competitors
- Practice size
- “Commodity” services
- Poor or no patient outcomes or satisfaction data
- Attitude

Evaluate What is Needed For Successful Contract and Costs

- If contract is data-driven, do you have IT and EMR-capability?
- Will you need to hire additional personnel, such as clinical care coordinators or data entry personnel?
- Is (additional) accreditation required?
- Is the payer mandating patient interventions and health education efforts?
- Must you follow specific protocols?
  - Carefully evaluate “program requirements” or “provider obligations”
Develop Payer Profiles

- Prior to contract negotiations!
- Will help you understand payer motivations
- Will help identify risks/benefits, strengths/weaknesses of various payers
- Plans, rates, denials, time to payment, populations, operations, outsourced functions
- Use your claims data to help flesh out profile
- Check with your staff, clinical AND revenue cycle

Understand the Payment Model

- FFS
- Episode-Based Payments
- Global Risk
- Risk
- Shared Risk
- Pure Capitation
- Less Risk
- More
Know what you’re dealing with

• Identify EXACTLY who/what is on the other side
  – HMO vs. PPO vs. Indemnity Plan vs. Self-funded ERISA plan vs. Medicare Advantage

• Identify “Covered Parties”
• Identify “Covered Product”
• Most contracts are template-based

Understand the Contract Template

• Is it a master contract with various insurance products included in schedules or attachments?
• Are there varying master templates for the different insurance products / lines / populations?
• Look at the definitions VERY carefully, especially “Provider”, “Payer”, “Client”, “Plan”, “Affiliate”. 
Sample Headings

Payer A
- Definitions
- Representations and Warranties
- Applicability of this Agreement
- Duties of Facility
- Duties of Payer
- Claims
- Dispute Resolutions
- Term & Termination
- Miscellaneous

Payer B
- Definitions
- Obligations of Provider
- Confidentiality / Records
- Insurance
- Relationship of Parties
- Indemnification and Liability
- Dispute Resolution
- Term & Termination
- Miscellaneous

Sample Table of Headings - Georgia Model Managed Care Contract

<table>
<thead>
<tr>
<th>ARTICLE</th>
<th>PAGE NUMBER</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preamble</td>
<td>1</td>
<td>Partie to end date of the agreement and general description of the agreement</td>
</tr>
<tr>
<td>1. Definitions</td>
<td>3</td>
<td>A enumeration of defined terms used throughout the agreement</td>
</tr>
<tr>
<td>2. Service of Services</td>
<td>12</td>
<td>Procedures for the determination of covered services and verification of employees eligibility</td>
</tr>
<tr>
<td>3. Compensation and Related Terms</td>
<td>16</td>
<td>Procedures regarding compensation for covered services including: Billing for covered services Coding for bills submitted Co-payments Coordination of benefits Payment, payment</td>
</tr>
<tr>
<td>4. Participating Physician's Obligations</td>
<td>30</td>
<td>Procedures regarding participating physicians obligations under the agreement including: License/Board Standing Nondiscrimination Assistance in procedural procedures Nondiscrimination with medical care</td>
</tr>
<tr>
<td>5. MCO's Obligations</td>
<td>36</td>
<td>Procedures regarding MCO's obligations under the agreement including: Adverse decisions about medical necessity or Payment to parties other than MCO Cooperation in understanding Physician grievances Benefit information Quality improvement</td>
</tr>
<tr>
<td>6. Records and Confidentiality</td>
<td>48</td>
<td>Procedures regarding confidential medical records, access to such records, and other confidential information</td>
</tr>
<tr>
<td>7. Termination</td>
<td>52</td>
<td>Procedures regarding terminating and the payment of expenses described therein</td>
</tr>
<tr>
<td>8. Miscellaneous</td>
<td>58</td>
<td>Miscellaneous but important provisions, including: Governing Law Indemnification Notice Assignment Change in Law Standards Agreement Non-Compete</td>
</tr>
</tbody>
</table>

Metrics

• What kinds of metrics will be used, and how are they calculated?
• Are the metrics fixed or do they change over time?
• If metrics are based on codes, what happens in light of annual updates?
• Who decides on the metrics?
• Can you negotiate any of this?
• Can you motivate your clinical staff to meet these metrics? Get input from your clinicians.

Term and Renewal

• Identify “Effective Date”
• Does the contract auto-renew? If so, is there any provision for otherwise updating rates or fee schedules?
• How long are you locked into the rates and with the payer? You need to balance locked in rates versus ability to update.
• How soon must you decide to continue or terminate and give notice? Usually 90 – 120 days before expiration. Does this leave you enough time to evaluate, consider next term and renegotiate if necessary?
• If you decide not to renew, make sure you have contingency plans and procedures in place for notifying patients on a timely basis (beware charges of abandonment).
Termination

• “With” and “without” cause

• What are the permissible reasons under the “for cause” termination provisions?
  – Should be serious infractions only
  – Beware of possible collateral damage

• Is there any opportunity to cure under the “for cause” reasons? If so, how much time is allowed?
  Is there any appeals process?

• How long is the “not for cause” notification period?

Payment provisions

• Timely filing deadlines
  – Do not assume these are all the same across payers
  – Tight deadlines put a premium on your practice’s ability to file a clean claim

• What constitutes a “clean claim”?

• Are prior authorizations required? If not routinely required, what are the circumstances where they are required?

• What about copayments and deductibles?

• Days to payment
  – Based on what? Claim submission date? Clean claim date?
  – Know your state’s timely payment laws

• Are payments reduced for failure to meet contract terms? For example, payment reduction for timely filing but beyond a certain time period.
Medical Necessity

• How is it defined?
• Who determines this - Physician or RN?
• Is prior authorization required?
• What is appeals procedure?

Audit and Refund Provisions

• How far back can the payer audit?
• How much notice do they have to provide prior to an audit?
• Are there any limitations on how many records they can request or how many audits they can conduct in a year?
• Is the payer itself doing the audits or are they outsourcing them to another company?
• What are the audit protocols and objectives?
• What medical necessity policies or coverage decisions will they be using?
Audits and Refunds (continued)

• How much time is allowed to refund? Are refunds done via off-set?
  – Beware of documentation and math issues with offsets

• What is appeals process? Does it seem fair?

Dispute resolution

• What is the complaint/dispute resolution process?

• In some states, it is in law. Texas Insurance Code §1301.055 – each contract must have complaint resolution process that provides for reasonable due process

• Is process internal or external?

• Is this process required before provider can file lawsuit? Does it prohibit you from filing appeal after the process?

• Who pays for costs?

• Does the contract limit your remedies if you win?

• Are you required to keep the outcome (and sometimes the fact of the dispute itself) confidential?
Credentialing

• Which providers/staff must be credentialed?
• How much documentation is required?
• How much time is typically needed for credentialing?
• Any prerequisites, like Medicare billing privileges?
• NAMSS managed care credentialing toolkit: https://www.namss.org/Portals/0/NAMSS%20Managed%20Care%20Resource%20Toolkit.pdf

Payer Fee Schedule Comparisons

• Compare top 25 CPT codes across top 10 payers
• Identify top reimbursement rates and bottom rates as ones to achieve and ones to avoid
• Compare to Medicare fee schedule; Medicare usually serves as a benchmark
• Look at data from a trade group such as MGMA
• If renewing, analyze what your write-offs are and why
Fee Schedule Issues

• Is reimbursement a fixed dollar or based on a percentage of a benchmark such as Medicare?
• Can payer unilaterally change fee schedule? Are there any limitations on this? What about notice provisions? Does this affect established patients?
• Can practice change fee schedule? How much notice does plan require?
• Are there any pay-for-performance modifiers or issues?
• Are there any carve-outs?

Silent PPOs and Network Rental

• PPO “leases” its provider network and discounts to another organization that don’t have networks of their own. Examples: workers’ comp, auto liability insurers, smaller plans and payers
• Patients appear to be out of network and physician charges accordingly
• But the third party administrator sends claim to a reprice (a middleman that has extensive database of plans, discounts and contracted providers)
• Reprice matches provider name and ID against database, picks lowest reimbursement and arranges temporary lease
Silent PPOs and Network Rental (continued)

- Beware of “all payer” and assignability clauses
- Fixes:
  - Clearly identify who payer is
  - Add clause preventing PPO from disclosing contracted discounts until lessee signs contract agreeing to plan that complies with your agreement
  - Add clause that any discount applied that is not part of the contract is forfeited, and provider has right to collect total payment
  - Require patients to show ID card with correct logo

Silent PPOs and Network Rental (continued)

- Fixes (continued):
  - Verify payer at time of coverage verification
  - Remove any loose or squishy language entirely
  - Make sure contract language is clear that patient steering is a material part of contract and that discount only applies if patient was steered to provider
- Future – 14 states may begin limiting (Texas) or banning silent PPOs (14 states, such as North Carolina)
Other Provisions and Issues

- Compliance program requirements
- Any minimum guarantee of covered lives
- Beware of payer permitting contract to expire and then asking you to honor fee schedule while new contract negotiated. Put a time limit to this. Get it in writing and do not agree to verbally extend the contract.

Provider Manuals

- Beware that provider manuals and materials on website may be contractually agreed to or incorporated by contract language
- Make sure you know how to / where to access provider manuals and ancillary documents such as coverage decisions
Termination / No Contract Strategy

• If you terminate or let contract expire, develop strategy to deal with patients
  – Consider if you are bound by a Non-Disclosure Agreement and whether or how this limits what you can say
  – Develop form letter for mailing and standardized script for call-ins

After Signing the Contract

• Stay on top of dates and deadlines
• Implement any new protocols, practices, etc.
• Monitor payments and denials
  – Timeliness
  – Full payment
  – Denial reasons/codes
• Evaluate whether the payer is performing to other terms of the contract
• Ensure staff are trained
• Consider periodic meetings with payer staff
Pro Tips

• READ ALL PAGES OF THE CONTRACT! All kinds of things can be hidden in the back pages.
• It’s up to you to stay on top of deadlines and response dates. The payer may be negotiating hundreds of other contracts and you may be small potatoes to them.
• Don’t be afraid to challenge plan actions.
• Send all critical communications via certified mail return receipt.

Questions?

• Thank you for your attendance!
• Get your questions answered on PMI’s Discussion Forum: http://www.pmimd.com/pmiForums/rules.asp