How To Get Contracted Into Closed And Narrow Payer Networks – “The Secret Sauce”

Presented By: Steve Selbst
CEO, Healthcents, Inc.
April 2017
Introducing Healthcents Leadership...

**Mr. Steve Selbst, CEO and Co-Owner**
- Manages Healthcents Operations including contract negotiations
- Successfully negotiated 15,000+ payer contracts
- Invented Revolution Software™ and designed the product
- 30+ years as a Healthcare, Software, and Business Development Executive including leadership roles at IBM
- BS Degree in Business Administration, Arizona State University, Summa Cum Laude and invited to apply for a Fulbright Scholarship

**Ms. Susan Charkin, President and Co-Owner**
- The Nationwide Expert in Payer Contracting and Strategy, well known
- President and Founder of Healthcents since 1994
- 15+ years of Senior Contracting Positions for payers and providers (Healthnet, BCBS, Aetna, University of California, San Francisco, Maxicare and others)
- Trustee of Natividad Hospital - largest public hospital in central California, a teaching hospital affiliated with UCSF
- Leading Author and National Speaker on Managed Care (Boston University, George Washington University, American Ambulance Association, Specialty Capitation, Beckers ASC EMS Insider and others)
- Expert in ACOs, put together key roadmap for AUA, interviewed Dr. Elliott Fisher, Brookings Institute, Blue Cross of CA and an early IPA implementer
- Undergraduate Degree in Education (UVM) and MPH Degree (USF).
Goals & Objectives

• Define Closed and Narrow networks and the implications to providers

• Learn how to navigate closed and narrow networks to get contracted and generate more revenue
Agenda

• Define Closed and Narrow networks and the implications to providers

• Types of Payer Contracts - which one(s) are best for you?

• What are payers looking for? “Ask not what the payers can do for you but what you can do for the payers”

• Learn strategies and tactics to get contracted with commercial payers who have closed or narrow networks
  ✓ Building effective value propositions
  ✓ Over come obstacles

• Steps to getting contracted - Good “payer contracting hygiene”
What is a closed or narrow network?

- **Closed** - Payer has established a practice (usually not a policy) that it is not accepting more providers into a specific network type - e.g., Orthopedic Surgeons, since its network is full.

- **Narrow** - Payer has established a practice (usually not a policy) that it is generally not accepting more providers into a specific network type - e.g., Orthopedic Surgeons, since its network currently has the optimal number of providers it needs.
Network Types

Open or “Any Willing Provider”: Narrow Network: Closed Network:
Why the distinction?

- It often is more likely that a provider with the right value proposition can get into a narrow network.
- Providers with unique and innovative offerings may be able to break into a closed network.
- Sometimes the two scenarios are effectively the same.
Payer Contracts’ Types

• **Commercial**
  - ✓ PPO, HMO
  - ✓ Fee for service, capitated, value based
  - ✓ Complementary (Direct PPO and Secondary)

• **Government**
  - ✓ Medicare (Medicare Advantage)
  - ✓ Medicaid
  - ✓ VA
Payer Contracts Types

- Complementary Primary Payer
- Primary Payer
- Complementary Secondary Payer
- Insurer
- Re-Pricer
- Complementary Payer

- Commercial Payers, ACOs, IPAs
- Commercial Payers, TPAs, Medi-Medi, Employers, VA
- Commercial Payers

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Method of Contracting

• Direct with Commercial Primary Payer

• Complementary Primary Payer
  ✓ PPO / HMO
  ✓ Medi / Medi
  ✓ ACOs
  ✓ ASOs / TPAs
  ✓ Self-Insured Employer Groups

• Complementary Secondary Payers
Which contract(s) are best?

- Am I price sensitive?
- Is my product useful to Medicare and Medicaid patients?
- Who are the large commercial payers in the area?
- Who are the large employer groups and which payers do they use to cover their employees?
Medicare Access and CHIP Reauthorization Act

• Payer contracts mostly continue to be Fee for Service Based with an expanding value based component

• “Doc Fix” bill, repealed the Sustainable Growth Rate (SGR) and replaced it with a new payment modality for Medicare payments

• 2015 to 2019, automatic .5 percent increases on Medicare physician fee schedule

• 2019 to 2025, reimbursement remains flat unless participating through MIPS (Merit Based Incentive Pay System) or APM (Alternative Payment Model)
What services and products do payers want?

• Based on an informal survey of large payers across the USA our findings are:
  ✓ **Service:** benefits that demonstrate better compliance and clinical outcomes at lower cost
  ✓ **Product:**
    • New technology that is a game changer and saves cost
    • Products which enable patients to move out of the hospital while awaiting surgeries
    • Alternative treatment to a surgery
  ✓ **Geographic:** advantages - serves rural/underserved areas
  ✓ **Referrals:** Lots of key referrals (specialists and ancillary providers)
    • Non Par Providers with high utilization
Continuing Market Trends

• Lower price points

• Narrowing networks
  • Trend toward capitated agreements for Medicare populations

• Caps on benefit maximum payments on certain devices
  • e.g. hearing aids
Consider this...

• Services in a given category are all similarly reimbursed by all payers.
• What do you do when cost is no longer a competitive advantage?
Implications to Providers

• You will likely need a unique value proposition to get into a closed or narrow network

• Often price competitiveness coupled with value is key; can revisit after initial contract term
Strategies for Closed and Narrow Networks

• First: Focus on a combination of pricing and value

• Complementary Payers

• “Any Willing Provider”

• LOAs
Tactics to get into narrow and closed networks

• First, there are no silver bullets

• Complete a SWOT Analysis with a focus on competitive differentiators
  ✓ Product related
  ✓ Service related
  ✓ Treatment outcomes
  ✓ Geography related
  ✓ Referrals
  ✓ Or all of the above

• Often price competitiveness coupled with value is key, can revisit after initial contracts term
SWOT Analysis

**Strength**
- Location
- Size and Market Importance
- Referral Network

**Opportunities**
- Employer Groups
- New or Specialized Products and Services
- Value Based Contracting
- Service Advantages

**Weakness**
- Competing Companies / Practices
- Payer Reimbursement Policy

**Threats**
- Mergers
- Payer initiated ACOs
- Out of Network Reimbursement Policy
## SWOT Analysis

Physician Practice Report for Payer 'Payer 1’
Company Name: Ortho Sample
Address: 555 Bell Road, Salinas, CA, 93908
Medicare Year: 2017

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* = This is a partial table for illustration purposes only

**Summary for CPT Codes with Medicare Rates and Payer Rates**

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<th>metric</th>
<th>value</th>
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<tbody>
<tr>
<td>Payer Average as % of Medicare</td>
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<tr>
<td>Payer Weighted Avg as % of Medicare</td>
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<td>Payer Total Revenue</td>
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<tr>
<td>Regional Avg % of Medicare</td>
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<tr>
<td>State Avg % of Medicare</td>
<td>122%</td>
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<tr>
<td>National Avg % of Medicare</td>
<td>139%</td>
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Service Advantages

- Do you have procedure(s) in your portfolio which are unique and will save the payer money and provide treatment benefits?
  - Procedures / techniques that reduce hospital readmissions
  - Use of robotic technology that improves clinical outcomes
  - Procedures reduces testing that eliminates biopsies
  - Use of device(s) that reduces diabetic foot ulcers and save limbs
Other Service Advantages

• Who are the key stakeholders in your referral network?
• Do you cover geographies that your competition doesn’t?
• Do you serve rural and underserved communities?
Treatment Advantages

• Do your services eliminate inpatient stay days at a hospital and move them into an office or ASC setting?

• Does your practice reduce the need for invasive surgeries?

• Does your practice enable alternative treatment to invasive surgeries?

• Does your practice improve patient health in a way that reduces payers’ costs?
What is "Value" to a Payer?

- If deployed, it has the potential to change the way that medical care is delivered, resulting in higher quality of care / better clinical outcomes with verifiable evidence.

- If deployed it has the potential to prevent currently unpreventable downstream cost with quantifiable savings.

- Improved delivery method that increases access and improves quality of care

- Improved technology that creates efficiency and lowers cost
Now let’s look at an example that focuses on service efficiency, as a template, that you can use and modify based on your specific value proposition!

This example assumes that the provider has submitted a request for participation but was told the network is closed.
Good afternoon Mr. or Ms. Payer Contracts’ Manager,

Mr. Doe responded to an initial request for our practice to participate in your specialty network and indicated that your network is closed. I am certain that there is a cost effective value proposition here for your organization that will bring your beneficiaries much higher quality orthopedic services at lower cost and with better clinical outcomes. Please consider this proposal for in network participation and I will have my assistant follow up to arrange a call. There are some very important facts I would like to call to your attention to that sets this practice apart from other orthopedic practices.

Our practice is a worthy candidate for network participation status because, with their operational efficiencies, they will compete on price, are dedicated to improved patient outcomes on non invasive surgeries, and use the newest robotic technology which is proven to reduce hospital readmissions by 30% for patient populations of 100 or greater.

Medical practice will provide high quality products for home use and save you substantial expense through its efficient patient first service model. They will do so in three specific areas:

- Ability to compete on price
- Successful surgical avoidance outcomes that far exceeds industry standards
- Service advantages
The Body, elaborate the value proposition:

**Price Competitive:** Company will beat the pricing of your current par providers. Practice has been providing orthopedic services for over 12 years and has a dedicated office staff in place for insurance verification. As a result of our best practices in patient verification, we onboard patients faster and more efficiently by allowing patients to get the care that they deserve with as little delay as possible. At the core of these efficiencies is the ability to compete on price and reduce the time that you will spend verifying our patients’ eligibility for services.

**Surgical Outcomes:** Improved Surgical Outcomes are at the center of our practice’s value to payer networks like yours. While most orthopedic practices focus on knee and shoulder arthroscopies, we have demonstrated and invoked a treatment plan which avoids about 30% of knee and shoulder arthroscopies and reduces hospital readmissions for those who require surgery by 30%. We have estimated the total savings per 100 patients treated to be over $200,000.

**Service Advantage:** We are the only orthopedic practice servicing regions x and y in our state. This means that your beneficiaries will not longer have to travel 100+ miles to the nearest practice to receive treatment and they will receive treatment at lower cost.
I look forward to discussing orthopedic practice’s participation in your PPO network and the items, listed above, that set us apart. I am sure that after you review the information in this letter that you will agree that adding our practice to your network is the right thing for your organization and for your beneficiaries. I look forward to receiving a positive reply by 6/1/2017. Please let me know if you have any additional questions or would like any additional information that will assist in enabling our par provider participation in your network.
Overcoming Obstacles

• Escalation - must be timed just right
  ✓ Recast the value proposition

• Broaden the aperture - more than one type of contract
  ✓ Direct agreements, ACOs, ASOs, self insured
  ✓ Complementary payers - direct and secondary
  ✓ Any Willing Provider
  ✓ Letters of Agreement - case rates
Best Practices for Payer Contracting

Phase 1: Prepare
- Data Analysis
- Proposal Letter
- Make Initial Contact with Payer

Phase 2: Negotiate
- Negotiate until agreement is reached
- Analyze Counter offers

Phase 3: Continue to Negotiate
- Escalate to Senior Management
- Consider Out of Network Option

Phase 2: Continue to Negotiate
- Monitor Claims
- Re-Negotiate

Negotiations Completed
Best Practices for Payer Contracting

**PREPARE:**

- **Best Practice 1:**
  - Evaluate top codes and figure out which ones are driving revenue

- **Best Practice 2:**
  - Benchmark against Medicare and other payers with which you have contracts to identify areas where you may be under reimbursed compared to the market. Use the “20/80” rule.

- **Best Practice 3:**
  - SWOT Analysis for your payer fee schedules: Look for opportunities to increase reimbursement for services that are not reimbursed at market competitive rates, and assess your chargemaster.

- **Best Practice 4:**
  - SWOT Analysis for your practice

- **Best Practice 5:**
  - Prepare an impactful proposal letter
Best Practices for Payer Contracting

**NEGOTIATE:**

- **Best Practice 6:**
  ✓ Deliver your proposal letter to the appropriate network manager, do initial follow up and establish rapport

- **Best Practice 7:**
  ✓ Follow up frequently and keep the payer representative engaged. Respond quickly to any requests they make for additional information and to any proposals you receive from the payer

- **Best Practice 8:**
  ✓ Evaluate payer proposals and look for ways to optimize counter offers. Don’t take first “No” as an answer, and use escalation to Sr. Management judiciously

- **Best Practice 9:**
  ✓ Review contract for language that affects reimbursement

**MONITOR:**

- **Best Practice 10:**
  ✓ Monitor payments, identify reimbursement issues quickly and work closely with your payer representatives to resolve any payment issues as quickly as possible
Trends and Directions

- Payer contracting implications of the new administration’s policies?
- Fee for Service still the name of the game in commercial payer contracts
- Medicare and commercial payers integrating performance based metrics over time with shift of greater percentage of reimbursement tied to incentives and value based contracts vs. FFS
- Limiting/reducing referrals to outside providers who are non-par (this includes facilities and ancillary providers, e.g., labs and radiology services)
- Bundled payments – still in exploratory stages, but expect to see more pilots and demonstrations among commercial payers
- ACO numbers (both the number of ACOs and the lives they cover) are expected to continue to grow, depending on new legislation may change
- Higher deductibles leads to the need for better patient collections
- Telemedicine is expected to gain traction among commercial insurers
- Continued M and A acceleration in provider sector (Payer mergers appear to be slowing down)
- “E-everything”, greater dependence on technology for care delivery, documentation and reimbursement
Summary

• Define your competitive advantage
• Identify your payer contact
• Leverage your existing relationships and referral networks
• Be persistent!

“I’m convinced that about half of what separates the successful entrepreneurs from the non-successful ones is pure perseverance.”

Steve Jobs
1955-2011
Your Free Contracts’ Assessment

- Contact Susan Charkin at 831-455-2695 or charkin@healthcents.com

- This ½ hour high value assessment is included as a part of this session

- If possible (not required), bring:
  - Revenue collected over a one year period for each payer
  - Overall % Medicare you are currently contracted by key payer
  - Any known issues with a payer, e.g., collections or other
  - Any knowledge you have about your competition and the market that you are in

- Susan will discuss approaches to moving each of your agreements forward to higher reimbursement(s) and / or other recommendations
Questions?

Contact the speaker at:

selbst@healthcents.com or 831-455-2174 or

www.Healthcents.com

• Our full suite of services include:
  ✓ Payer contracting analysis and negotiations
    o Including letters of agreement, claims trouble shooting, and claims payment verification
  ✓ Online Marketing Outreach
  ✓ RevolutionSoftware™, our unique cloud-based contracting software
  ✓ Education and training in payer contracting
  ✓ Consulting packages customized for your needs
  ✓ Led by a team with decades of healthcare and technology expertise
  ✓ Healthcents is the go-to authority for organizations such as the AAOE, American Urological Association and Quill Healthcare (a division of Staples)
  ✓ We have presented at many industry venues such as this one

More information at www.healthcents.com