PAYER NEGOTIATION – A 10 STEP PLAN

Step 1
Do your homework

Step 2
Prepare an Impactful Proposal Letter

Step 3
Submit your proposal to the Payer Contracts’ Manager

Step 4
Follow up to get your response.

Step 5 (A)
Payer replies w/counter offer

Step 6 (A)
Analyze counter proposal, negotiate until agreement is reached.

Step 7
Review your contract documents

Step 8
Sign and Return Contract and Complete Credentialing Requirements

Step 9
Track reimbursements for compliance

Step 10
Renegotiate at the end of your term

Step 5 (B)
Payer will not negotiate

Step 6 (B)
Escalate to next level manager, and, if necessary Sr. level manager

IF PAYER WILL NOT NEGOTIATE, YOU MAY WANT TO CONSIDER OUT OF NETWORK OPTION
**Step 1 – Do your homework.**

Study your current contracts and fee schedules:

Review your contract terms. Know your term and termination language and comply with notification requirements. For example, it is not uncommon for payers to require 90 to 120 days notice in advance of your contract anniversary date to advise them that you do not want to continue in your agreement. Many payers also use this notification period as the time in which they will entertain requests to renegotiate your contract.

**Benchmarking your reimbursements against local Medicare Rates** is a simple way to determine where you stand and gives you a starting point from which to identify weaknesses in your current reimbursement. The revolution spreadsheets benchmarking tools, which is part of this web service and that you purchased, enables you to evaluate your current reimbursement in a variety of ways: including revenue, volume, procedure type, average of Medicare reimbursement, and to provide an overall average and weighted average of Medicare reimbursement. Weighted average considers the influence that volume and pricing by code has on a particular code’s reimbursement in your overall revenue from a payer. It is a way to insure that you take into account the work flow through you practice so that surgeries and office visits that produce the most revenue (volume*payer allowable) are focused on most in the negotiations.

**Understand the payer’s reimbursement structure.** It is important when you are preparing your fee schedule proposal to make sure it that is consistent with and fits the payer’s methodology. For example, if your reimbursement is based on a proprietary payer fee schedule, it does not make sense to propose reimbursement rates as a percentage of Medicare. Likewise, if the payer reimbursement structure is based on a % of Medicare reimbursement, it does not make sense to propose a fixed rate fee schedule. The exception to this is when you are proposing reimbursement for Key Codes. Key Codes are usually the top 10 – 20 procedures that represent the core of your business and for which you want special reimbursement consideration. Note that even if your current agreement does not recognize key codes, you should always ask for special consideration of your key codes. It never hurts to ask. The worst that can happen is that the payer will say “no”. But you can use this as a negotiation “give” to “get”.

Once you have benchmarked all of your payer agreements, you will have the ability to perform comparative analyses across codes and payers. This information will help you prioritize your negotiations and provides you with invaluable empirical data to support your request for an increase. Additionally, this benchmarking data will be the basis to develop a fee schedule proposal for each payer to include in your proposal letter.

In addition to benchmarking your payer reimbursements and understanding your reimbursement structure, it is a good idea to **evaluate your billed charges**. The Bill Charge Modeler, part of RevolutionSoftware web service that you purchased, helps you to manage your charge master rates to insure that bill charges are set at reasonable levels for both your in network and cash paying patients. In general, if your billed charges are set at about 250% of Medicare, you can usually avoid being penalized by any “lesser of billed charges or ….” language that may be in your contract. Generally, the key is to insure that your billed charges are well above...
your payer-contracted rates and set at a reasonable UCR threshold. In the absence of other information, 250% of local medicare rates for codes is generally a good default assumption.

Before *you make a proposal*, determine how far you can push and what your options may be if the payer is unwilling to negotiate. Before you contact the payer, it is a good idea to answer the question: “Am I willing to go out of network?” The **Out of Network Modeler** allows you to model and compare your current and projected contracted rates in a payer's network vs. out of network revenue based on a set of assumptions that you make based on what you know about your practice, patients and the local market.

Finally, make sure you know who your contact is. In most cases, with most payers, your market is assigned a network / contracts manager. These individuals have many titles: Provider Engagement & Contracting Representative, Contract Manager, Provider Network Manager, Provider Services Representative, and Contract Negotiator/Consultant. This person’s contact information may be identified on the cover letter or previous correspondence that you have received from the payer. If you do not have correspondence, and do not already know your local network manager, you can usually contact provider relations services for your local network management representatives. In many cases, the contact information that you need can also be found on the payer website. If you are contacting a provider network department, be sure to ask for the contract manager for your geographic area. In some cases, depending on where you practice, you may be directed to submit your request to a department, rather than an individual. In this case, submit your proposal and call the department weekly until you get the name of the person to whom your negotiation has been assigned, or until you receive correspondence from the assigned representative.

**Steps 2 & 3— Prepare and Submit an Impactful Proposal Letter**

Now that you have done your homework, the next step is to prepare an impactful proposal letter. Your subscription includes a **Sample Impactful Proposal Letter** and **Tips for Preparing and Impactful Proposal Letter**, so we will not belabor the nuts-and-bolts here. Please refer to this section of the web site. In general, the purpose of the proposal letter is to focus the payer’s attention on the value of your practice to their network. Remember, that **value** is in the eye of the beholder. The beholder is the payer in this case. Focus on tangible financial value where possible, such as revenue the prior 12 months received from this payer, number of patients treated during this same period, unique services, geographic advantage etc. Read the proposal letter section of this site carefully and use the sample as the template and integrate the advice provided.

Your proposal letter needs to, as much as possible; help the payer see your practice from your point of view. Bottom line, this letter is a sales pitch, but do not make the mistake of selling your fee schedule proposal. What you are selling is the irreplaceable service you provide to their covered lives. Payers are business entities focused on profit generation; many are publicly held corporations that 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.
Step 4 – Follow Up
The payer will take approximately four weeks to internally evaluate your proposal. This is normal. Once you have submitted your proposal letter, you should follow up weekly with the payer contact to track their progress. Payers may ask for more time to do a financial or actuarial assessment of your request. This is also normal. You will need to judge each circumstance to be sure that the payer is focusing on your offer and using the time to prepare a reasonable reply or counter offer.

Steps 5 & 6 – Payer Engagement.

Scenario A: The Payer Replies with a Counter Offer.

The scenarios at this point vary considerably. Generally, you may find that part of the proposal is acceptable to the payer and part is not. The payer may make a reasonable and acceptable counter offer, or the payer’s counter proposal may be unacceptable. At this point, you can use the benchmarking tool to evaluate the payer’s offer. Compare the proposal to Medicare and to your proposed rates. Once you have benchmarked the counter offer, you can decide on your next steps. If your next step is to accept, then move on to steps 7 through 10. If you are making a counter proposal, go back to Step 3, but focus on the areas where you do not agree with their counter offer and reiterate the substantive points from your original proposal letter to support your request. Repeat this process so long as forward progress is being maintained and an agreement is on the horizon. If at any point the negotiations reach an impasse, you may need to escalate up the payer’s management chain to move things forward. Escalation strategies are discussed below.

Scenario B: The Payer will not negotiate.

This can occur in a few different ways. 1) The payer responds with “we have a state/regional fee schedule.” Or 2) “Your fee schedule is market competitive.” If the payer declines to enter into negotiations in any form, your next step will be to respectfully request the names and contact information of the first level contract manager / negotiator’s supervisor and the supervisor’s supervisor. Keep in mind, in many cases, the first level negotiator does not have any decision-making authority, but they could be an advocate for you with upper management. Keep your communication with the first level negotiator professional and cordial. Though it may be tempting, DO NOT LINE JUMP or start your interaction with the payer by telling the first level payer contract negotiator that you plan to escalate. Always try to work a contract to completion with the first level negotiator before escalating. Otherwise, it is very likely that the manager will kick your request back down to the first level negotiator and is tantamount to burning a bridge you will definitely need in the future. In the case of the payer who has a state/regional fee schedule, in some cases, if you push back, you will find that the payer does have the ability to develop an enhanced fee schedule for a single provider or group, but the burden is then yours to make the case that you are so needed and critical in the network, that it is in the payer’s best interest to come to the table with a better reimbursement offer than they are offering similar providers in their network.

For escalations, if you have the personnel available, you may want to have your billing manager initiate contact with the payer’s first level negotiator. When escalating, you can bring in your practice manager who can be more firm and push harder with the upper manager. As negotiations progress and you are
working with senior level management to finalize negotiations, it is a good idea to have your senior management work with the payer’s senior management to finalize negotiations. On your end, get an advocate involved who can strongly and clearly represent the practice’s needs from an owner/shareholder perspective. In many cases, this person has the ability to help turn the tide in the practice’s favor and close the deal. This person may be the medical director, practice manager, or CEO, depending on the size and organization of your practice. This is where teaming and leveraging the personnel in your practice can be helpful.

In some cases you may decide that you need to go to the top of the payer’s organization in order to progress negotiations to completion. If the payer is absolutely not coming to the table, write a letter to the office of the president in your state. You may also ask to have your request reviewed by the Payer’s Medical Director. Though the Medical Directors represents the payer, they can sometimes bring a provider’s perspective to the negotiation. In some cases, the Medical Director can sway the contracting department’s decision by supporting or validating the provider’s point regarding delivery of care efficiencies (i.e., surgical codes that are routinely performed in the office setting). At this point, you do not have anything to lose and taking your request to the top may give your request the extra weight it needs to move the contract negotiators in your direction.

**Steps 7 & 8 – Review, Sign and Return Your Contract**

If the payer engages in negotiation and an agreement is reached, the payer will send you the contract documents for signature. Check to verify that it includes the reimbursement rates and terms that you agreed to. Check for key operative language that may effect your reimbursements such as:

- **Term and Termination** – it is preferable to have termination without cause *unrelated* to your anniversary date. Ask for 90 days without cause, if possible, again unrelated to your anniversary or renewal date.
- **Time to submit claims** – Ask for 365 days from date of service to provide time to submit secondary insurance claims. 120 is not an uncommon default in payer agreements.
- **Changes to Claims** – Ask that the contract require the payer get your written permission prior to adjusting, re-coding, re-ordering or in any way modifying your claims.
- **Retroactive Adjustments** – Make this time as little as possible after claim submission. 90 days or less, is preferable.
- **Refunds/Re-payments** – Ask that the contract require the payer to request payment from you directly, rather than making adjustments in future claim reimbursements.

It is recommended that you have all payer agreements reviewed by your legal counsel, prior to signing and returning the document to the payer. Also, keep in mind, many payer agreements have standard language and, much, if not all of this language may not be negotiable. A good rule of thumb is to focus on language changes if and where operational problems have manifested in your practice.

You may also receive a credentialing or re-credentialing application with your contract documents. Most payers will not load the contract terms and rates into their reimbursement system until the credentialing application and supporting documents are completed, returned and processed. Make sure to handle these requests in an expedient manner to ensure that the effective date of your new or amended agreement is not delayed.
Once you sign your agreement, make a copy of the entire package for your file. Send the completed credentialing applications, supporting documents and partially executed agreements to the payer as directed via a traceable courier, such as USPS Certified/Return Receipt Requested, DHL, FedEx, UPS or similar courier, and track delivery.

After a payer receives the partially executed agreement and credentialing materials, it may take up to 60 days for the contract to be “loaded” into the payer’s system. Until the contract is loaded, your new rates will not take effect. In most cases, you will not have an effective date on your partially executed agreement, or the effective date will be referenced as “60 days from the date of final execution” or similar language.

Once the contract has been implemented you should receive a fully executed copy of the document for your records, usually within 90 days from the day they receive it. If you have not received your fully executed copy within 90 days, and you confirmed receipt, you should follow up with your negotiator to find out what is holding up implementation of your agreement.

**Step 9 – Track Your Reimbursements.**
After you receive your copy of the fully executed agreement, and confirm that your contract is effective, it is a good idea to check your EOP / EOB’s for the first few months, and periodically thereafter, to make sure your reimbursements are consistent with your contracted rates. If you find inconsistencies, you should notify your negotiator immediately. You should simultaneously immediately appeal any claim that is not reimbursed according to your contract. Appeal instructions will be included with the EOP / EOB.

**Step 10 – Renegotiate**
The payer will not contact you at the end of your term to see if you want an increase. You must be diligent and whenever you are not being compensated at an acceptable rate, covering costs and providing a profit, you need to contact the payer – go back to Step 1. Do not procrastinate, renegotiate!

**ADDITIONAL CONSIDERATIONS FOR THE CURRENT HEALTHCARE ENVIRONMENT:**

1. **Plan for the possible impact of changes by the recently passed healthcare legislation to Medicare and to provider reimbursements.** While the various proposals under consideration would likely retain the multiplicity of commercial health plans in play today, there is still some speculation that the U.S. government may eventually create a government-sponsored payer to compete with commercial payers. Such an outcome would further increase the pressures on physicians to perform services at lower reimbursement levels.

As you know, many physicians are looking at possible significant decreases in Medicare reimbursements. Many payers follow Medicare guidelines for determining both charges and reimbursement.
Pick 10 of your primary cases and determine the cost of providing care for each. Unbundle CPT codes and account for all services including ancillary services such as anesthesia, lab, radiology, pathology, supplies, etc. Having this information can assist you in explaining the cost of providing your services and can be used to justify your requested increased reimbursements to payers during contract negotiations.

2. **Prepare for Pay for Performance.** It is important to track the trend of quality and costs since physicians’ fees will, at some point, most likely be linked to Pay for Performance. Pay for Performance programs link physician adherence with recommended case management processes and protocols to financial incentives. These programs should be measurable and based upon key clinical indicators. The managed care industry is actively working with CMS to help develop appropriate standards for such future implementation.

The National Committee for Quality Assurance has been a central figure in the movement towards P4P. NCQA works with large employers, policymakers, physicians, patients and health plans to determine measurements and improvements in this arena. NCQA’s Healthcare Effectiveness Data and Information Set tool is used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service.

As such, it is worthwhile to start preparing now for P4P by collaborating with your major payers by reviewing ongoing efforts by NCQA in developing HEDIS standards and compliance goals, and knowing how/when these will impact your PRACTICE. Also note that there should be simple methods to administer and monitor quality and cost so both you and the payer can easily understand your indicators. Toward this end, compliance protocols, policies and reimbursement methodologies should be spelled out in detail in the body of your payer agreements or as separate amendments.

3. **Develop and monitor standard quality of care measures.** Patient care is improved as a result of the sharing of ”best practices” and creating aggressive quality management and utilization review programs. For example, it is recommended that Physicians go well above the Medicare baselines for chart review, as well as maintaining detailed data and documentation on their hospital readmissions and infection rates. Physicians should also verify and document their continual compliance with internal group and PRACTICE protocols.

Physicians should regularly exchange metrics, ideas and thoughts concerning patient care and practice efficiencies. Consider the institution of a monthly morbidity and mortality report, development of best practice models for operational efficiencies, institution of standardized protocols for commonly performed clinical conditions as well as standardized reporting for in-office surgery and diagnostic testing. Again, these practices will assist you in preparing your PRACTICE for future payer reimbursement under any new P4P and/or Medicare reimbursement methodologies.

4. **Consider forming a physician "super-group."** Physicians first dipped their toes into collaborative ventures to enhance patient access to services and control quality via the formation of lithotripsy cooperatives. Physicians’ next logical step towards controlling their destiny is to fully integrate solo and small group practices into financially and clinically fully integrated group practices. These new entities have resulted in demonstrated improved efficiencies, including reduced treatment and non-treatment costs, improved outcomes, expanded patient access and improved healthcare services for both insured and non-insured patients alike. These group practices cannot exist in name only but need to satisfy the unified business test, which implies a very high level of integration. It is also important to note that these entities are required to comply with both local state and
federal guidelines. Any such structure should be developed with legal counsel that is familiar with both local state and federal guidelines regarding integrated practices.

5. Consider expansion into ancillary services. Additional advantages to the economies of scale offered by a large group practice are traditionally termed ancillary services. However, large group practices have introduced a new comprehensive urological care model enabling physicians and their Physicians to have some form of control over all the services that impact the patient, such as diagnostic radiology, laboratory and pathology services. However, before getting started, contact each of your contracting and non-contracting payers individually for their credentialing and payment protocols since each will have completely different policies and procedures relative to this issue.

If you build it does not necessarily mean the patients will have automatic access to your new services. This is as much as credentialing issue as a contracting issue. Assuming that these new services are covered under your existing tax ID number, you need to first determine if any of your physicians will be credentialed and can be reimbursed when providing both the professional and technical components of these new services. Also, determine if there is additional credentialing or accreditation requirements that the payer is going to require for these new services such as accreditation by the American College of Radiology.

Payers, regardless of your geographical presence or market power, may be unable to contract with you if they are already contracted either exclusively or via capitated rates for these ancillary services with another provider. Remember that payers often view physicians who provide both the professional and technical components of non-urological ancillary services much like having the fox running the hen-house; payers will look at your utilization of these services much more closely as overutilization becomes an increasing concern.

Also, Medicare is currently reviewing its rules relative to the relationship of specialists who provide ancillary services, such as pathology, which may or may not change in 2010 and beyond. Regardless, payers are constantly evaluating these issues. Just because they have given you the green light for reimbursement today does not preclude them from altering these policies and procedures in the future unless you get it in writing in your payer agreements.

6. Implement a common electronic health records platform. EHRs enable patient records to be easily exchanged between different physicians (either different specialties or within the same specialty). All laboratory, diagnostic studies and clinical information should be in a central repository, and should be updated on a real-time basis. Your EHR should be designed around evidence-based protocols, further guiding your physicians to improving clinical care. Leverage technology for electronic prescriptions (which will also virtually eliminates errors in transcription and side effects from unpredicted drug interactions), as well as electronic storage of media such as radiographs. These steps will reduced your infrastructure costs as well as provide you with documents needed in justifying fees to health plans for new and renegotiated agreements.

7. Provide new services, equipment and technology. A major advantage to both patients and third-party payers is the ability for patients to obtain highly specialized services from new, state-of-the-art treatments and equipment. Payers are now looking at contracting with Physicians whose physicians have advanced fellowship training. The use of new technologies can improve outcome, increase throughput and reduce costs, both directly and by reducing patient morbidity.
It is essential to maintain complete cost and patient quality care records as you provide these services and use these pieces of equipment. Tracking the use of these advanced services and technologies will assist you in documenting a payer’s cost per episode of care, and in turn can provide you with the compelling data and documented needed to justify your requested rate increases during payer contract negotiations.

8. Implement and document ongoing physician continuing education. Establish programs to ensure that your physicians are continuously receiving training so that patients receive the highest level of medical care. The most progressive Physicians and their physicians now provide their physicians with monthly scientific presentations either delivered or arranged by their chief medical officers, and organizations hold monthly morbidity and mortality conferences. Arrange to provide didactic and hands-on training for your physicians to ensure standardization of technique and reporting with respect to key services such as ultrasounds.

Furthermore, it is a good idea to conduct regular meetings, mandatory to all physicians, at which national thought leaders provide state-of-the-art lectures on various clinical subjects. In addition to clinical information, it is also imperative to update physicians regularly on healthcare policy and operational issues. To demonstrate your commitment to quality of care provided in your community, open your scientific meetings to both your member and non-member physicians alike without cost or obligation. In taking these extra steps, you will be able to demonstrate intent as a collaborating partner with both your community and your local health plans.

9. Implement aggressive procedure coding review. Ongoing statistical modeling regarding coding error rates and accuracy should be performed by your PRACTICE. Physicians should be educated on correct coding initiatives on at least a quarterly basis. These initiatives ensure that each patient receives the correct treatment for the disease entity, and that the bills reflect the appropriate charges for the service. This will increase both patient quality of care as well as reduce the likelihood of audit retrospective review, denial of payment of past claims, and possible payer recoupment and recovery of money from future services.