PRACTICE NEGOTIATIONS - A STEP BY STEP GUIDE

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It is well accepted by providers that the costs associated with running a practice continue to escalate, including employee health coverage, technology costs for electronic medical records systems, compliance regulations, HIPAA compliance, malpractice expenses, and increases in rent to name a few. Understandably, staff would also like raises to match cost of living adjustments, at least. These costs do not include the endless and often needless arguments and phone calls by staff and physicians to payers (insurers) to obtain authorization for medications and imaging. This process can easily take hours to address just one patient's needs. One study estimated the total annual cost of interacting with a health plan was $68,274 per physician, per year.[1] It is challenging for any practice to truly measure the "hassle factor" of working with a payer as the reimbursement rate does not account for the additional time and effort needed to manage additional requirements of a payer when providing clinical care and/or billing.

Many practices across the country feel limited in the ability to negotiate with commercial payers. The purpose of the following pages and accompanying lecture is to provide the practitioner and administrative leadership within a practice an insight into the potential opportunity to develop a better relationship with commercial payers through improved reimbursement rates and contractual relationship terms. Of note, there are many factors that must be taken into account in these discussions. It is important to recognize that each individual's circumstance is unique and must be factored into the communication approach with a payer. The following suggestions should be considered as only potential guidelines, recognizing that each practice, each payer and each market will have its own issues, challenges, and solutions. The practice will be required to adjust strategies accordingly.

STEP 1: UNDERSTAND THE PRACTICE FINANCIALS: THE FORREST AND THE TREES

Before any communication is made with a payer, the practice must understand its current business model. In addition to reviewing this syllabus, we encourage you to review the AAN Compensation and Benchmark survey available at www.aan.com to help you benchmark your financial operations compared to your peers and better understand some of your internal and external strengths and weaknesses.

Providers are unable to communicate with other practices regarding reimbursement rates due to contractual obligations. However, providers may glean a sense that they may be paid less than others. This may be understood through the challenges faced by the practice to recruit other providers compared to colleagues for instance, presuming everything else is relatively equal. Colleagues may also be placed in higher tiered products by commercial carriers, suggesting that they may be paid more for the same services rendered. Utilizing a master fee schedule will allow the practice to evaluate the reimbursement rates from each payer objectively.

Successful negotiation will require not only understanding the forest from the trees, but also understanding the trees from the forest. Understanding the overall finances of the practice are paramount, including the revenues and expenses separately. The practice must understand the fee schedule per payer and which codes are most relevant to the practice as well. Payer A may pay $80 compared to payer B at $100 for a typical follow-up visit, but perhaps the practice's revenue derives almost solely from EMGs and Payer A pays $400 compared to Payer B at $350 for this service. In this case, the practice may want to pay more attention to Payer B as the volume of charges by the practice might suggest this code is more important than the other codes due to aggregate collections, even if the insurer pays higher individually on other codes.

The practice should know the top 25 CPT codes it utilizes and the associated reimbursement rates. Most practices will likely generate 80% of their revenue from these particular codes. Excluding Medicare, insurers will

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rarely give their payment schedule for all CPT codes at once. Obtaining the financial reimbursement of the codes utilized as much as possible is nonetheless critical. Additional information about fee schedules, RVUs, payer analyses, etc. may be found at www.frankcohengroup.com. Additionally, quantification of the "hassle factor" (also known as the Administrative Burden Index) associated with working with a particular payer is important. For instance, a payer's reimbursement for a particular CPT code may be $5 more than the equivalent Medicare code. However, if the payer does not reimburse in a timely manner for the clean claim and/or the claim must be reworked, the practice biller may need to expend additional time and effort to collect monies owed. A clinical visit may also result in additional paperwork and/or phone calls to obtain an imaging study or medication approved. These additional efforts generate a cost. Thus, if the average cost for the particular code noted above costs the practice $10, the "true" reimbursement for that particular code is $5 less than the Medicare rate. This may be a discussion point with payers when in negotiations.

STEP 2: DETERMINE FEASIBILITY OF A NEGOTATION IF THINGS GO SOUTH

1. Understand the payer mix. If a payer is more than 40% of the practice mix, the practice may have a significant uphill battle that is not feasible to overcome should it stop participating with that payer. The practice may still ask for an increase, but the practice may be less inclined to consider discussing contract termination. Of note, the payer mix may be different per physician depending on types of patients seen. The practice may need to assess the individual payer mix to assess the effects per physician.
2. Understanding the fee schedule per payer and the practice billing patterns (ie. number of units billed per code) will allow you to develop a sensitivity analysis. This is typically a spreadsheet designed using cell based formulas such that you can alter one variable and determine its effects on multiple other variables (cells) resulting in varying outcomes. An example would be building a formula within a cell that multiplies the number of units billed over a year for a particular code with the reimbursement rate specific for a particular payer. This will result in a total dollar amount of money generated for the year based on the code billed. Altering either the number of billed units or dollar amount will alter the final total income. By adding the payer mix into the analysis, resulting in a weight adjusted table, one can get a rough estimate of the effects of a payer within the practice in various positive and negative scenarios. The practice can alter the payer mix to generate a worst case, likely case, and best case scenario of how the payer mix will change at 3 months, 6 months, or 1 year if the practice decides to stop participating with a particular payer. With enough information in the spreadsheet, the practice can determine the total financial contribution of the respective payers. See Figures 1 & 2.

Figure 1. Sample Sensitivity Analysis Assessing Payer Financial Impact- Positive Outcome

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1							Payer Mix:			Weight Adjusted Financial Return:					
2											Current:		Projected % retention/incr:		
3	Procedure Code	Practice Charge	Insurer 1	Insurer 2	Medicare	# billed units	Insurer 1	Insurer 2	Medicare	Insurer 1	Insurer 2	Medicare	Insurer 1	Insurer 2	Medicare
4							16%	43%	41%				15%	112%	112%
5	99203	$207	$86	$119	$115	30	5	13	12	$413	$1,535	$1,416	$62	$1,719	$1,585
6	99204	$315	$132	$180	$175	332	53	143	136	$7,012	$25,697	$23,833	$1,052	$28,780	$26,693
7	99205	$389	$165	$222	$216	324	52	139	133	$8,554	$30,929	$28,715	$1,283	$34,641	$32,160
8															
9															
10	99211	$39	$19	$21	$22	10	2	4	4	$30	$90	$88	$5	$101	$99
11	99212	$84	$28	$48	$47	10	2	4	4	$45	$206	$191	$7	$231	$214
12	99213	$139	$53	$73	$77	632	101	272	259	$5,359	$19,838	$19,944	$804	$22,219	$22,338
13	99214	$203	$85	$115	$113	3753	600	1614	1539	$51,041	$185,586	$173,507	$7,656	$207,856	$194,328
14	99215	$271	$110	$164	$151	1085	174	467	445	$19,096	$76,514	$67,079	$2,864	$85,696	$75,128
15															
16									Totals:	$91,550	$340,396	$314,773	$13,732	$381,244	$352,546
17															
18									Total Gross Income:			$746,719			$747,522
19															
20									Net increase/decrease in income after dropping Insurer 1:						$803
21															
22									Split by 5 doctors:						$161
23															
24									Income/physician gain after personal income taxes (30%):						$112

In this example, each of 5 physician owners' revenues improve by *not* participating with insurer 1 at the current reimbursement rates as they benefit from insurer 2 and Medicare's higher reimbursement rate with increased number of patients seen by these two payers, *and* retention of 15% of the patients by insurer 1 who are now paying out of pocket. This is a good case scenario, even without negotiating.

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Figure 2. Sample Sensitivity Analysis Assessing Payer Financial Impact- Negative Outcome

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1							Payer Mix:			Weight Adjusted Financial Return:					
2										Current:			Projected % retention/incr:		
3	Procedure Code	Practice Charge	Insurer 1	Insurer 2	Medicare	# billed units	Insurer 1	Insurer 2	Medicare	Insurer 1	Insurer 2	Medicare	Insurer 1	Insurer 2	Medicare
4							16%	43%	41%				15%	100%	100%
7	99205	$389	$165	$222	$216	324	52	139	133	$8,554	$30,929	$28,715	$1,283	$30,929	$28,715
8															
9															
10	99211	$39	$19	$21	$22	10	2	4	4	$30	$90	$88	$5	$90	$88
11	99212	$84	$28	$48	$47	10	2	4	4	$45	$206	$191	$7	$206	$191
12	99213	$139	$53	$73	$77	632	101	272	259	$5,359	$19,838	$19,944	$804	$19,838	$19,944
13	99214	$203	$85	$115	$113	3753	600	1614	1539	$51,041	$185,586	$173,507	$7,656	$185,586	$173,507
14	99215	$271	$110	$164	$151	1085	174	467	445	$19,096	$76,514	$67,079	$2,864	$76,514	$67,079
15															
16									Totals:	$91,550	$340,396	$314,773	$13,732	$340,396	$314,773
17															
18									Total Gross Income:			$746,719			$668,902
19															
20									Net increase/decrease in income after dropping Insurer 1:						-$77,817
21															
22									Split by 5 doctors:						-$15,563
23															
24									Income/physician loss after personal income taxes (30%):						-$10,894

In this example, each of 5 physician owners' revenues diminish by *not* participating with insurer 1 at the current reimbursement rates as they do not gain additional patients from insurer 2 or Medicare.

a. *There are no case controlled, randomized, peer reviewed studies that will tell you what the realized payer mix will become*. Business principles in this context rely on the following:
    i. Historical data: Look at similar practices within the market that may have left a particular payer in the recent years… Is there any information to suggest what retention rates of patients from the particular payer was after contract termination? A reasonable benchmark of patient retention for a well-regarded practice in a middle-upper class community would likely fall between 10-40%. Additionally, have there been any internal changes to the payers in terms of leadership and approach to physicians or how large employers in the market may affect payers' flexibility to increase reimbursement rates to a practice. The Affordable Care Act has also affected payers' approach to healthcare and understanding how the payer may have been affected may be relevant.
    ii. Prospective data: Survey your patients prior to termination: "If the practice separated from Payer A, would you: A) stay with us (& pay out of pocket), B) Not sure, C) Leave?"
b. Does the practice have a prolonged wait list? The average neurologist has a wait list of 34.8 business days, longer than many other specialties and primary care providers.[2]
    i. Long wait lists may allow the practice to leverage its negotiating position as the list may shorten but not become diminutive. Thus, terminating a payor's contract may not be detrimental financially to the practice. The practice may become more available to patients with other insurances, allowing the practice to benefit from higher payments per patient.
    ii. However, understanding the potential degree of patient decline if contract termination is necessary will help determine the financial impact should negotiations not succeed.
    iii. It is *critical* to understand that the relevant impact of diminished patient visits must reflect the providers with the shortest wait list. A practice with less established physicians or physicians located in communities with significant provider competition may have shorter wait lists. These physicians could find themselves at significant financial risk if their office hours are devoid of patients. This is a pertinent point should the practice be considering any mergers or acquisitions of other practices as well. Larger organizations are not

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always better for purposes of negotiations if the organization is a collection of individual practices scattered in an expanded area and competition is fiercer amongst certain practice offices in separate markets. Furthermore, are other physicians within the practice near retirement? Diminished visits result in diminished income. The loss in income to senior physicians for long term gains may not be as appealing. All providers must fully understand the risks of any negotiations that may end in contract termination.

c. Determine the current market saturation of other neurologists. This may be accomplished by reviewing the payer's website and searching for the local neurologists. Keep in mind that the geographic distance a payer considers reasonable may be different than what the practice would have felt is reasonable. Other options could include reviewing nearby hospitals' websites for staff neurologists, internet searches using key words "neurology" or "neurologist" and the names of the nearby towns, and industry representatives.
d. Note that some payers may have additional clauses that can cause administrative confusion even after termination. For instance, if a provider decides to stop participating with a particular payer, the payer members with PPO products may become members of another payer and thus these patients become in-network again. Thus to completely separate from the original payer, the practice may be required to separate from another payer or payer program, affecting even more patients than planned. This may generate confusion amongst patients and staff in attempts to decipher this clearly.
e. Further, some payers may not directly reimburse providers for emergency services rendered in a hospital. The payer will pay only the patient and the patient will then be responsible for paying the provider. Unfortunately, not all patients reimburse the providers the money received from the payer.

STEP 3: REACHING OUT TO THE PAYER

1. Understanding the practice's current contract provision carefully and comprehensively is imperative: The practice representative may communicate with a payer at any time, but the timing to stop participating with a payer may be limited due to the current contract provisions.

   This Agreement shall be effective for an initial term ("Initial Term") of _____ (__) year(s) from the Effective Date, and thereafter shall automatically continue for additional terms of one (1) year each, unless non-renewed as of the anniversary date of the Effective Date by either Party with at least sixty (60) days prior written notice to either Party.

   In this case, the provider must provide the payer written notice within 2 months (and only 2 months) of the initial term date in any given year. The timing of this is important as the provider would not be able to terminate "at will" without potential breach of contract.

2. Determine who the contact person is at the payer:
   a. Start with the payer representative (Network Account Manager/Provider contracting Manager) the practice communicates with routinely. This person will likely have no authority to determine practice rates. However, he/she may be helpful and advocate for the practice if the practice has a good relationship with the payer's representative.

   b. Often the decisions regarding reimbursement rates will fall to an individual with a title such as "Vice President Provider Network" and the practice may be able to determine who this is and reach this person by asking the representative or the regional medical director for the company, internet searching this title with the name of the company (and geographic area if the company is national), searching LinkedIn website, or asking other practices that recently negotiated whom they interacted.

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COMMUNICATION WITH PAYER:

1. Honey is more effective than vinegar. If one's ultimate goal is to come to an agreement, presenting oneself as overconfident with bravado, sense of entitlement, etc. will likely result in a failed negotiation. Further, ultimatums should never be used unless one is absolutely confident the practice is ready for either outcome. Remember, the communication is with another human being who may or may not appreciate the practice's perspective and it will be the role of the practice's representative to be respectful at all times, yet assertive as the negotiations continue. Maintaining the facts during discussions will mitigate a less favorable emotional response from the payer.
2. It will be necessary to write a letter or email the payer to explain why an increase in reimbursement rates is reasonable, regardless of verbal conversations. Highlighting positive traits of the practice may have value. This could include:
    a. Highlighting one's unique skills compared to peers and demonstrated level of quality care.
    b. Utilization of evidence based guidelines.
    c. Demonstrating high patient satisfaction scores through surveys.
    d. Discuss how the practice communicates, collaborates, and shares data with referring physicians.
    e. How the practice saves money for the payer. Quantitative analysis within the practice of costs of care for each patient covered by the payer may have significant value if it appears money is saved by the payer. This may include using low cost labs and hospitals, use minimum required testing, apply treatment protocols to keep patients controlled and out of the hospital, and minimization of patient cost sharing by prescription of generic medications. Payers are also more likely to appreciate quality and cost savings based on outcomes rather than demonstrating application of quality processes. For instance, verifying a decrease in patient visits to the ER due to migraines is likely more interesting to a payer than documenting that the provider asked a Parkinson's patient if they fell since the last visit.
3. Data metrics derived by practices are becoming increasingly important to payors. Metrics can occur as outcome measures or process measures. Outcome measures, if available, are preferred. This may include the number of prescriptions for imaging of headache disorders or frequency of emergency room visits of your patients. Process measures are generally less difficult to obtain, though may have less relevance to a payor. They may include the frequency the providers asking if a atient with Parkinson's disease fell since last visit. Larger practices may have more resources to track and provide outcomes or process information. However, if quality data was reported to Centers for Medicare and Medicaid Services (CMS) thru current government based quality initiatives, smaller organizations may find some useful information due to CMS' Quality and Resource Use Reports (QRURs). This is a report that tracks reported quality metrics and the costs generated by a particular practice, based on the tax identification number. Further, if the practice collaborates with the AAN thru the Axon Registry, the practice may also have additional quality data to objectively support quality scores within their practice compared to other neurology practices across the country.
4. Within this letter, the payer may request the practice provide how much of an increase the practice is requesting, and over what time period. Reimbursement rate contracts are often determined (and re-negotiated) yearly or over multiple years. Contracts more than 4 years may be detrimental to the practice due to unknown changes in the environment, including inflation rates.
5. Physicians are not permitted to communicate with each other regarding current rates due to risk of breach of contract with commercial payers and independent physicians cannot unionize or perform collective bargaining due to risk of anti-trust laws, such as the Sherman Anti-Trust Act. Few websites may offer a glimpse of benchmark rates, such as www.healthcarebluebook.com and www.fairhealthconsumer.org. However, it is impossible to verify these rates due to the lack of transparency by commercial insurers.
6. Simply asking for a reimbursement rate escalation may yield an increase without further argument and a second increase request may also be feasible without any further negotiations.
7. Of note, payers will often be slow to respond to providers. Payers are not in the business to "give" providers more money. Be prepared to wait 2-4 weeks per communication, if not longer, from the payer. More than a month delay in communication suggests unnecessary delay. If communications appear too delayed, the practice may express concern and displeasure to senior management of a payer if feasible.

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One may find that as the deadline for cancelling a contract nears though, the payer may surprisingly expedite responses to avoid contract termination.

STEP 4: WHAT HAPPENS IF THE PRACTICE AND THE PAYER DISAGREE ON RATES?

1. A number of arguments may be used to suggest the practice's rates are already reasonable. These could include concerns that payers would need to increase premiums for their members, the practice is receiving the same rates as all other practices, the practice is at the "usual and customary rate," or the practice is already receiving higher rates. Payers may also legitimately feel pressure to maintain low rates due to aggressively negotiated contracts by employer organizations. The practice may need to provide responses to these claims.
2. The practice will need to determine what level of risk is acceptable. Can it afford to no longer participate with that payer?
3. To consider terminating the payer contract, the practice must judge the ramifications of this decision and develop predictive models of the implications of termination.
    a. As noted above, financial assessments of current and potential changes in practice revenues and expenses are critical for moving forward.
    b. All physicians within a practice should understand the potential of income reduction and how severe it may be. Further, if there is a reduction, how long can the physicians feel comfortable out of network?
    c. If not done yet, a survey of current patients planning to remain with the practice or leave it may be use at this juncture.
    d. Other considerations/questions:
        i. What will be the opinion of community physicians? Will referral patterns change? Are physicians used to colleagues going out of network for periods or is this a new concept to them? Will they be upset or understand the importance of what you are doing and be supportive? Will the community physicians be willing to spend the extra time to find and refer patients with other insurances? Can you make it easier for referring physicians to still refer patients to you?
        ii. If affiliated with a hospital, will the hospital understand and support your efforts, perhaps reach out to the payer on your behalf? Or will they put pressure on you to re-enter a contract with the payer? If the practice provides care to patients within the hospital, how will those services be affected after the practice stops participating? Will the practice be able to bill the payer for emergency services rendered despite not participating, or will the practice need to bill the patient directly? Could patient satisfaction levels diminish at the hospital as a result, generating negative hospital or media attention? Is there any concern of less admissions or services to the hospital because the practice is out of network? Will that affect your relationship with the hospital(s)?
    e. The practice should have talking points ready to communicate to its patients, colleagues, media, human resources of various companies, and legislators the practice's concerns and what they can do to assist the situation, such as calling and writing letters to the payer and legislators regarding concerns for access to care. State medical societies may also have resources available.

STEP 5: TERMINATION & THEREAFTER

Depending on one's contract, termination may not be allowed except during a defined period as noted above. Verify if there is a window and if so, what the window is to ensure that the practice can terminate. Timing of termination towards the end of a year may or may not also be useful as members may appreciate the opportunity to have choice of different insurance plans to ensure their visits with the practice will continue to be covered. Of note, some payers may provide an additional grace period whereby the patients may be able to temporarily prolong their "in-network" coverage. From the payer's perspective, this is to allow the patient some limited time to find an alternate provider while still under your practice's care.

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Prior to termination, ensure the practice is ready for a number of upcoming changes. This includes the following:

1. All providers and staff must understand the situation. Both staff and providers will require training in what communications to provide to patients whom are currently members of the terminated payer. Printed and discussed "talking points" are critical to ensure the messaging is consistent and meaningful to the audience of interest. Negative, emotional, or opinionated commentary about a payer to the community will generally not be an effective strategy. The payer contract that was signed by the practice may limited the practice to only informing the patient the practice will no longer participate with the payer as of a particular date, despite participation termination.
2. Pricing strategies need to be in place prior to termination as well. What will the practice charge patients for the visits or procedures? Does the practice want to reduce its overall charge rates for patients to encourage out-of-network patient visits?
   There are a few caveats to pricing:
   a. The charge amount is what out-of-network patients will be expected to pay. Ensure charges are reasonable and patients can afford to pay this cost.
   b. Payers may include a "most favored nation" clause within their contracts. This allows the payer to only pay the provider the lowest charge the physician bills to any other payer. Charging patients less than what is received by government contracts such as Medicare is illegal as well. However, practices may offer "time of service" discounts which may allow patients to pay less than contracted rates if the patient pays <u>at the time of service, within the same business day</u>. Practices may offer the patient a 10-25% discount on the charged rates if the patient pays in full at the time of the visit. This is acceptable practice because this time of service discount is also offered to all other payers.
3. Physician and staff leadership will need to ensure workflow changes are understood and follow-up conversations/meetings will be necessary to adjust for unexpected workflow effects due to the termination.
4. Monitoring the effects of the termination is also vital: how has the practice's wait list been affected, have referral patterns changed? While income may decrease due to a decrease in volume, has there been a proportionate increase in income due to a payer mix with more favorable payers or patients paying out of pocket?
5. Do you need to consider marketing to colleagues and/or the community via outreach lectures, web site, or print advertisements?

<u>STEP 6: NEGOTIATING THE CONTRACT AFTER AGREEING TO REIMBURSEMENT RATES</u>

Agreeing to reimbursement rates is an incredible success. Undoubtedly, it will require a compromise on both ends. However, the practice may have an additional opportunity to ensure the contract is also more balanced and reasonable. There are a number of potential clauses that a practice may have the flexibility to alter. However, it is critical to decide what, if any, clauses may also be a deal breaker for the practice to become in-network again.

Examples of contract clauses that may be desirable to change:

1. <u>Pre-defined termination period</u> within a given year. See above for additional details.
2. If the addition of a new provider had a pre-existing participation agreement through another practice, then the provider may be paid by the payer at the same rate as the <u>pre-existing agreement</u> from the <u>other</u> practice.
3. <u>Retroactive referrals</u>: Except for Emergency Services, payment for retroactive referrals may be subject to adjustment or denial by the payer. *What if a patient is seen urgently in your office, not emergently? Can you get paid for this visit without the referral in advance?*
4. The payer may notify the provider of overpayments and the provider agrees to return any such overpayment or payment made in error within a reasonable period of time. *The practice may define what is reasonable…. 180 days, 6 months, but not indefinite.*

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5. Determine what, if any, are the obligations of the payer to pay the provider for clean claims in a timely manner. Are there state laws that oversee this issue and is there an interest penalty if the payer does not comply?
6. Hold harmless clause- The payer prohibits balance billing patients for the costs of non-covered services, unless the services are contractually excluded such as cosmetic and experimental procedures.
7. Payers may have multiple programs embedded within a contract, including commercial insurers, Medicare programs, worker's compensation. It is important to determine if you wish to see patients in only select programs.
8. Most favored nation clause (see above)
9. Implied acceptance of notification- Payers may notify providers of a contract amendment and offer providers only very limited time to object. Failure to communicate an objection within the brief time offered by a payer may result in implied acceptance of new contract language that is not acceptable to the practice. The practice may be able to insert contract language requiring the practice provide written consent prior to any practice amendment.

STEP 7: CONTRACT SIGNED, ANYTHING ELSE?

Once a practice leaves a payer's network, the practice may need to re-credential from scratch. This will affect the speed at which time the practice may begin to see revenues return from the payer. Further, referral patterns from community physicians may have changed and significant effort through personal and public relationships and marketing may be needed to return the practice to the prior level of referrals.

If all the above can be accomplished and the practice is successful in obtaining a more reasonable relationship with its payer, congratulations! The practice should be very proud!

References

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