Objectives

- Think through why your practice should bother to ask for a raise.
- Prepare in advance of the negotiations, getting organized with your data.
- Define your practice’s value proposition to the payors.
- Learn strategies for negotiation, including fixes for frustrating coding denials.
- Make permanent improvements to your payor contracts.
Look familiar?

WHY BOTHER?
It’s your practice’s paycheck

You probably have more leverage than you think

Practices do succeed – if it is given priority:

April 6th: Contract improvement requested with payor
23 different contacts over 4+ months
August 15th: +7% increase (year 1)
plus +5% increase (year 2)
Intangible Benefits

- Copies of agreements
- Defined fee schedules
- Mutual written amendment only
- 90-day without cause term
- COLA for additional years
- Current (or best) year of Medicare
- GPCI defined (e.g. Atlanta vs. Rest of GA)
- No/known homegrown fee schedules
- Define current payor contacts
- Appropriate charges (in excess of maximum contracted allowable)
- MPR defined, etc.

NOTE:
Mandated fee schedules are not negotiable
The market place is getting smaller – payor consolidation

Colorado Payors circa 2001
- Aetna
- Affordable
- Alliance
- Anthem BCBS
- Antero Health Plan
- Beech Street
- Colorado Access
- Community Care Network (CCN)
- Community Health Plan of the Rockies (CHPR)
- CorVel
- Concentra
- CIGNA Health Care
- CompreCare
- Coventry Health Care
- First Choice of the Midwest
- First Health
- GEHA/PPO USA Network

Colorado Payors circa 2021
- FOCUS
- Great-West
- Humana, Inc.
- Kaiser
- MedRisk
- MetLife
- Mountain Medical Affiliates (MMA)
- Mutual of Omaha
- MultiPlan (Viant)
- One Health Plan
- PacifiCare
- Private Healthcare Systems
- Prudential
- Rocky Mountain Health Plans
- Sloans Lake
- Take Care
- Western Health Plan
- United Healthcare
MultiPlan
THE WALL STREET JOURNAL.

• How Four Private-Equity Firms Cleaned Up on MultiPlan
  http://on.wsj.com/2dOrlB1

• “All told, private-equity owners have booked profits of about $5 billion on MultiPlan, which is a sort of middleman between doctors, patients and payers, helping to process claims and supplement gaps in insurers’ networks of approved doctors.” (emphasis added)

How to Find out if you’re contracted with MultiPlan:

• Provider Services:
• 800-950-7040 for Multiplan
• Option 2, then 2, then
  – Press 3 for fee schedule code allowables
  – Press 5 to check participation status
  – Press 8 to request a copy of network contract
  – Press 9 to terminate.
Typical HMO Premium Distribution

Medical Loss Ratio: $400

- **85% Premium ($340)**
  - Physician ($106 pmpm)
  - 100% Professional Costs
  - In-Office Labs
- **Hospital/Facility/ASC ($370 pmpm)**
- **Ancillary ($64 pmpm)**
  - Pharmacy
  - DME
  - Lab/Pathology
  - Therapies: PT/OT/Speech
  - Chiropractic
  - Mental Health
  - Vision
- **15% Premium ($60)**
  - Administrative Costs
  - Profit
RESOURCES for gathering Payor Data for Your State:

- **HMO:** your state’s Department of Insurance
- **PPO:** proprietary, broker or employer advocacy group
- **Medicare Advantage:** Medicare beneficiary website
- **IPAs/PHOs:** hospital websites, under “Payors we Accept”
- **Workers’ Compensation Carriers:** State Board of Workers’ Comp
- **Auto/Lien Payors:** claims adjustor for large insurers, like State Farm; lawyers with non-insured cases

Tip!
Ask hospital where you are applying for privileges for their Director of Managed Care, who should be able to provide list of payors and contact info.
Payor Mix (Example):

- United Healthcare: 20.8%
- BCBS-CO: 14.0%
- Medicare B-CO: 14.0%
- Medicaid-CO: 14.0%
- Cigna/HealthSource/GHW: 10.0%
- Aetna & Affiliates: 9.2%
- Humana: 9.2%
- Champus/Tricare WPS: 8.9%
- Self-Pay (cash): 7.0%
- Colorado Access: 6.0%
- Rocky Mountain Health Plan: 3.0%

Time commitment (minimum)

- Phase 1: 20 hours
- Phase 2:
  - 100 hours
  - 6+ months
GATHER DATA

DATA NEEDS:

- Tax ID(s)
- Copies of existing payer agreements
- Current fee schedule with charges for all CPT codes and HCPCS codes
  - Supply invoices/cost
- Frequency count of CPT code (for a given period, like 2020)
- Frequency count of ICD-10 codes (for example, 2020)
- Payer mix (volume of patients under each insurance type by products or product line, such as Medicare Advantage, HMO, PPO)
Bonus Data

- Cost-of-Living increase Argument:
  - Malpractice premiums
  - Rent
  - Own health insurance
  - Staff salaries

Determine how your Participation Agreements are held

- For each physician
- Individually, Group, IPA
PREPARE, PREPARE, PREPARE

Create a High-Level Summary:

<table>
<thead>
<tr>
<th>Payer</th>
<th>Percent of Revenue (2020)</th>
<th>Effective Date of Agreement</th>
<th>Fee Schedule Base</th>
<th>Fee Schedule %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payor A</td>
<td>3%</td>
<td>7/1/2015</td>
<td>Proprietary</td>
<td>105%</td>
</tr>
<tr>
<td>Payor B</td>
<td>11%</td>
<td>5/1/2014</td>
<td>Proprietary</td>
<td>108%</td>
</tr>
<tr>
<td>Payor C</td>
<td>9%</td>
<td>9/1/2018</td>
<td>Current Year Medicare</td>
<td>122%</td>
</tr>
<tr>
<td>Payor D</td>
<td>3%</td>
<td>4/1/2017</td>
<td>Current Year Medicare</td>
<td>120%</td>
</tr>
<tr>
<td>Payor E</td>
<td>17%</td>
<td>11/1/2016</td>
<td>2016 Medicare</td>
<td>97%</td>
</tr>
</tbody>
</table>
Look up Medicare Allowables

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

<table>
<thead>
<tr>
<th>Payer</th>
<th>Percent of Revenue (2020)</th>
<th>Effective Date of Agreement</th>
<th>Fee Schedule Base</th>
<th>Fee Schedule %</th>
<th>Current Year Medicare Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payor A</td>
<td>3%</td>
<td>7/1/2015</td>
<td>Proprietary</td>
<td>105%</td>
<td>92%</td>
</tr>
<tr>
<td>Payor B</td>
<td>11%</td>
<td>5/1/2014</td>
<td>Proprietary</td>
<td>108%</td>
<td>107%</td>
</tr>
<tr>
<td>Payor C</td>
<td>9%</td>
<td>9/1/2018</td>
<td>Current Year Medicare</td>
<td>122%</td>
<td>114%</td>
</tr>
<tr>
<td>Payor D</td>
<td>3%</td>
<td>4/1/2017</td>
<td>Current Year Medicare</td>
<td>120%</td>
<td>120%</td>
</tr>
<tr>
<td>Payor E</td>
<td>17%</td>
<td>11/1/2016</td>
<td>2016 Medicare</td>
<td>97%</td>
<td>92%</td>
</tr>
</tbody>
</table>
## Payer Resource Manual

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>DESCRIPTION</th>
<th>Freq.</th>
<th>Payor 1</th>
<th>Payor 2</th>
<th>Payor 3</th>
<th>Payor 4</th>
<th>Payor 5</th>
<th>Payor 6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>100%</td>
<td>115%</td>
<td>145%</td>
<td>100%</td>
<td>130%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Proprietary</td>
<td>Proprietary</td>
<td>Medicare</td>
<td>Medicare</td>
<td>Medicare</td>
<td>Medicare</td>
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<td>Weighted Average Reimbursement</td>
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<td>$121.35</td>
<td>$122.54</td>
<td>$140.85</td>
<td>$117.01</td>
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<tr>
<td>Weighted Percent of 2021 Medicare</td>
<td>100%</td>
<td>115%</td>
<td>145%</td>
<td>100%</td>
<td>130%</td>
<td>108%</td>
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<td></td>
</tr>
<tr>
<td>64634</td>
<td>Destroy c/th facet jnt addl</td>
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<td>$190.11</td>
<td>$231.09</td>
<td>$231.94</td>
<td>$231.48</td>
<td>$251.27</td>
<td>$193.28</td>
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<td>Destroy lumbar facet jnt</td>
<td>1007</td>
<td>$417.92</td>
<td>$461.73</td>
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<td>$413.38</td>
<td>$554.02</td>
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<td>Inj paravert f jnt c/t 1 lev</td>
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<td>$190.40</td>
<td>$226.97</td>
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<td>$188.37</td>
<td>$252.46</td>
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<td>$58.49</td>
<td>$62.25</td>
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<td>$81.97</td>
<td>$89.57</td>
<td>$72.41</td>
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<td>$132.74</td>
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<td>$44.97</td>
<td>$49.43</td>
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<td>76942</td>
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<td>$62.00</td>
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<td>77002</td>
<td>Needle localization by xray</td>
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<td>$114.72</td>
<td>$92.74</td>
<td>$124.29</td>
<td>$95.60</td>
</tr>
</tbody>
</table>

### Non-RBRVS-valued Codes:

- Lab
- X-ray
- HCPCS
  - DME
  - Supplies
  - Injectables
Objective

• Define your practice’s value proposition to the payors.

Now what?

0% Identify Payor Contact

10% Draft & Send Health Plan Proposal

20% Follow-up with Payor

30% Receive Offer(s) from Payor

40% Accept Rates

50% Read Language & Request Revisions

60% Language & Rates Acceptable

70% Signature on Contract

80% Contract Returned Correctly – Rates Loaded

90% Credentialing Approved

100% Effective Date

100% Credentialing Approved
## Identify Payor Contact

<table>
<thead>
<tr>
<th>Insurance Company Name</th>
<th>Contact Name</th>
<th>Title</th>
<th>Phone &amp; Fax</th>
<th>E-mail</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>BCBS</td>
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<td></td>
</tr>
<tr>
<td>CIGNA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humana</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Healthcare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Contracting Strategy #1:

- **Demographic Update for Payors**
  - **Clean-up:**
    - Type of agreement (group, individual, etc.)
    - Providers listed under the Agreement/Tax ID
    - Office locations appearing under Tax ID
    - Fee Schedule being paid to each physician
    - What product lines are participating and/or request client listing
Contracting Strategy #2:

- Address Material Change Notices

Respond:
- Is the payor:
  - ... restricting your lab providers?
  - ... Bundling codes together
  - ... Freezing your rates on a fixed year of Medicare
  - ... Lowering payments for specific procedures

Health Plan Proposal

- Send in a written request.
- Define your practice to Payor.
  - *Value proposition* to the health plan & patients
    - # of patients seen
    - Extended hours, in-office services, etc.
    - Ancillary services, if problematic for payment, such as imaging or lab
    - Supplies (HCPCS codes)
  
- State your reimbursement needs.
  You are your best cheerleader!
NEW & AWESOME DEVELOPMENT for Payor Contracting:
Hospital Pricing Transparency


Follow-up with Payor

- Acquire verbal commitment.
- If no verbal agreement, ensure payor understanding.
- Represent Practice’s unique circumstances.
  - Codes.
- Ensure circumstances are represented in calculating acceptable rates.
Expect a “No” or a Nominal Cost-of-Living Increase:

“I am unable to increase your current reimbursement as I show it is already above market in [city]. Please let me know if you would like to discuss.”

For a Provider on the Health Plan’s “Market Fee Schedule:”
“Our unit cost trends in [market] across the entire network are roughly 3%.

“I did review our proposal of [up $1 on the conversion factor] and compared to other [specialty] groups we have contracted and that is a [Payor] market competitive rate. With that said, at this point – I do not believe it is warranted to give any more than what is already on the table. While this most likely is not the answer you were seeking – this is the position that [Payor] is going to take. I know it is a business decision you will have to make as to whether or not you remain contracted in our network and we hope that you do on behalf of your patients our members.”

Objectives

• Learn strategies for negotiation, including fixes for frustrating coding denials.
Key Terms

• Rates
• Termination
• Amendment

Sample Language: Rates

Proprietary Fee Schedule: “100% of the then current (PAYOR) Fee Schedule, which is subject to change.”

“25% off Provider’s billed charges OR where federal or state mandated fee schedules applies, Provider agrees to 10% below federal or state fee schedule.”

✓ Surgery, Radiology, Medicine, E/M: 120% Medicare (2020)
✓ Drugs/Injectables: 100% ASP (OR AWP) Pricing
✓ Lab/Pathology: 100% 2020 Clinical Lab Fee Schedule
**Sample Language: Term/Termination**

“This agreement has an initial term of three (3) years.”

*and . . .* Continuing care obligations after the agreement remains in effect. . . (provisions remain in effect)

Evergreen: This agreement shall be automatically renewed each Anniversary Date for additional periods of one (1) year unless either party provides the other with ninety (90) days prior written notice.

*Either party may terminate this Agreement without cause by providing the other party ninety (90) days prior written notice of termination.*

---

**Sample Language: Amendment**

“In the event payor makes a *material change* in the terms of this Agreement it shall provide at least ninety (90) days written notice to Provider of such change. Provider must object within XX days . . .”

Payor may amend this Agreement upon sixty (60) days’ written notice to Provider to comply with regulations . . .

*This Agreement may be amended in writing as mutually agreed upon by both parties.*
Endure the Negotiation Process

- Keep stakeholders apprised
- Commit everything to writing
- Ensure language is acceptable.

Only once you agree on a rate:
Get Counter-Executed Agreement:

It’s not over until . . .

- Watch for “Welcome Letter” to practice
- Effective date = ultimate confirmation
- CE Agreement = legal document

Objectives

- Make permanent improvements to your payor contracts.
Now what?

- **0% Identify Payor Contact**
- **10% Draft & Send Health Plan Proposal**
- **20% Follow-up with Payor**
- **30% Receive Offer(s) from Payor**

- **70% Signature on Contract**
- **60% Language & Rates Acceptable**
- **50% Read Language & Request Revisions**
- **40% Accept Rates**

- **80% Contract Returned Correctly – Rates Loaded**
- **90% Credentialing Approved**
- **100% Effective Date**
- **Policy Reimbursement For Accuracy**

Educate Stakeholders

- Get **front desk schedulers & pre-auth coordinator** information on Payors

---

*Practice ABC (as of 1/1/2018)*
- Red Light = Health Plans that ABC does NOT accept. **DO NOT SEE PATIENTS**
- Yellow Light = Health Plans that ABC does accept, but is out of network
- Green Light = Health Plans that ABC does accept
- Purple Light = Health Plans that provider specific

*NOTE:* This document is NOT a replacement for performing eligibility checks. If you are still not sure whether ABC accepts the patient’s insurance, please call the payer on the number on the patient’s card.

- Anthem Healthcare, Inc. - HMO/PPO/OPO/POPO, Express Choice, managed Choice POS, Anthem Choice POS II, Anthem Select, Open Choice PPO, National Advantage
- Anthem Healthcare, Inc. - Medicare Advantage HMO
- Anthem Workers Compensation (AWCA)
- Anthem Allplan Plans
- Anthem Premier Care Networks
- Anthem Blue Cross Blue Shield (BCBS) HMO/PPO (Including Anthem Gold PPO with or w/o X in plan name)
- Anthem Blue Cross Blue Shield (BCBS) Managed Indemnity
- Anthem Blue Cross Blue Shield (BCBS) Medicare Advantage HMO
- X. Anthem Exchange Products (Anthem Pathways HMO)
- Anthem Exclusive Centers (AnthemPath)
- Beech Street - PPO - Multiplan - can see patients, but ABC is out of network
- CHAMPVA
- ChoiceCare Networks (qamana, Inc.)
- CIGNA HMO/PPO/POPO
Share effective date and new reimbursement data with billing staff.

Example for Payer Monitoring:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>DESCRIPTION</th>
<th>Alpha HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>Office/outpatient visit new</td>
<td>$112.62</td>
</tr>
<tr>
<td>99203</td>
<td>Office/outpatient visit new</td>
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</tr>
<tr>
<td>99204</td>
<td>Office/outpatient visit new</td>
<td>$257.24</td>
</tr>
<tr>
<td>99211</td>
<td>Office/outpatient visit est</td>
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</tr>
<tr>
<td>99212</td>
<td>Office/outpatient visit est</td>
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<td>99213</td>
<td>Office/outpatient visit est</td>
<td><strong>$140.62</strong></td>
</tr>
<tr>
<td>99214</td>
<td>Office/outpatient visit est</td>
<td>$199.37</td>
</tr>
</tbody>
</table>

Renegotiation Schedule

- Mark calendar
- Stay proactive
- Conscientious monitoring
BEWARE:
Contract loaded in-correctly by Payor

• Agreement for 180% Medicare
• Loaded (incorrectly) at 120% Medicare
• Not caught by billing company for >1 yr.
  – $15,000 in lost revenue
• Payor offered 270% of Medicare for 6 months, beginning in January
  – (new patient deductibles)
• Practice agreed to 200% of Medicare (indefinitely) to recoup/offset lost $$$

Make sure your billers know what they are doing:
GO GET IT!!!
NEVER GIVE UP

QUESTIONS?