

NEGOTIATING REIMBURSEMENT IN A PAYOR CONTRACT: NOT MISSION IMPOSSIBLE, AND YOU SHOULD CHOOSE TO ACCEPT IT

By

James (Jim) Dobbyn

Physician Practice Management Healthcare Services

And

Nick Healey

Dray, Thomson & Dyekman, P.C.

Negotiating or renegotiating a payor contract for your medical practice can be one of the most important steps you can make toward improving the practice's financial health. In the current healthcare reimbursement environment, physicians may (justifiably) feel that their medical practice's financial viability is being threatened. Most medical practices are finding a larger percentage of the fees they receive is fixed. There is little (or no) room for fee flexibility with Medicare and Medicaid, combined with the ever present threat (and reality) of cuts to the Medicare Physician Fee Schedule. As national economic challenges mount, health care providers find themselves with a greater percentage of uninsured, underinsured or "no pay" patients. Physician practices need to look hard at the financial areas over which they have some control, and try to maximize those areas. One of these areas, whether you feel it or not, is fee reimbursement.

Prelude: Physician, Heal Thyself.

Medical practice reimbursement is a hydra, the multi-headed beast of myth. It encompasses financial issues, community service issues, and patient access issues. Any of these issues is worth writing an article on. However, this article focuses on addressing the financial implications of deciding to, and following through on, renegotiating a commercial payor contract.

Reimbursement is an area that many physicians overlook when determining how to improve their practice's financial health. Reimbursement rates are often taken as a "given" by physicians. That those rates could (and should) be negotiated does not occur to them. Even if the practice feels it is not being reimbursed fairly by a particular payor, many physicians would prefer to concentrate on improving financial areas of the practice in which they feel comfortable than renegotiate. Negotiation implies confrontation, which is not only uncomfortable, it goes against many physician's basic natures. Conflict is rarely part of the healing process in which

physicians are trained. Likewise, negotiation implies haggling to some physicians, which is distasteful and clearly not why they got into medicine in the first place. Thus, many physicians, whether consciously or unconsciously, allow the reimbursement levels in their payor agreements to stagnate or worse, decline. However, looking at your practice's reimbursement levels is one of the best ways to ensure you have the healthiest practice possible.

Step One: Deciding To Renegotiate.

The first decision is one that is usually taken as a given by health care providers, but it is one of the most important: Should your practice have a preferred provider agreement with a specific payor? Becoming a “preferred provider” or “in network” for a payor means that, in return for agreeing to the reimbursement rates offered by a payor, the payor agrees to give you access to patient that you may not otherwise have. Patients, by and large, will usually go to a “preferred provider” for their payor over an “out of network” provider. There can be many reasons for this; the payor may require the patient to pay more of the cost of treatment out-of-pocket if provided by an “out-of-network” provider, or the payor may do a good job of promoting its network of providers. Therefore, there is usually some advantage to being a “preferred provider” for a particular payor.

The “Preferred Provider”: What’s the advantage?

Many practices want to be “preferred providers” for payors, fearing exclusion patient sources if they are not. However, it is worth recognizing that agreeing to be a preferred provider means agreeing to the payor's reimbursement schedules, and thus giving up some measure of autonomy in your practice. In making this decision, you should give thought to the following:

- How many patients in your market area are covered by this particular payor?
- How many providers in your specialty area already have preferred provider contracts with this payor?
- What other health entities (i.e. hospitals, surgical centers, DME companies) have preferred provider agreements with a particular payor?
- If you decide not to be a preferred provider, are there significant administrative and billing challenges for your practice if you treat patients that see you “out-of-network”?
- Do you have the capacity in your practice, in terms of volume, to handle the additional patients that may come with being a preferred provider, and if the answer is “maybe”, do the reimbursement rates you will receive justify the added cost of treating those patients?

Step Two: Review The Payor Agreement.

If you've decided that your practice should be a “preferred provider” with a particular payor, the next step is to review and understand the terms of that relationship, including the reimbursement levels. These are set out in the provider agreement that you (should) have with the payor. With an existing payor relationship, pull out your current agreement and make sure you understand the terms you have in place. If you are establishing a new “preferred provider”

relationship with the payor, ask for a copy of the payor's standard plan agreement. This may or may not include a proposed fee schedule, but will give you the standard "boiler plate" from which to start.

How long is it, and can I get out?

If you have a current agreement, start with determining the "term and termination" provisions of the contract. This will control how long the contract is in effect and when (and if) you can renegotiate. Some contracts can be very restrictive as to your time frame for renegotiating. Typically, the "term and termination" provisions are viewed as "boilerplate" and thus either unimportant or not able to be changed anyway, and so not worth being concerned with. However, ignore the "boilerplate" at your peril! Some of the most important parts of the contract can be "boilerplate". This does not mean, thought, that they are (a) not important or (b) unable to be changed.

The contract language probably does not allow you to renegotiate reimbursement levels whenever you want. However, it may allow you to renegotiate at specific intervals (ie. annually). If the agreement does not give you any reasonable options for renegotiation, you may have to go to the payor and ask to discuss renegotiation. Some payors will be cooperative and work with you on renegotiating reimbursement levels. After all, it does not help payors to have networks full of physicians that harbor a grudge against the payor. Other payors may be more restrictive. If so, check to see when the agreement expires. If it does not expire soon, and you want to renegotiate, you may be forced to move into the termination process to renegotiate. Check the agreement's termination provision to see if you can terminate the agreement prior to its expiration. Most payor agreements have some type of "without cause" termination provision, meaning that either party can simply terminate the agreement without either party having done anything wrong. Many such agreements require that you give written notice (such as 90 days) before terminating the agreement, although the timing and notice requirements may be complicated and the termination option may only be able to be exercised at specific times. You should consult with your legal advisor before terminating the agreement, as there are potential downsides to termination that should be considered. However, if you have gone through the analysis above with respect to whether you need to be a "preferred provider", then you will be in a good position to know whether the potential benefits are worth the potential downsides.

Step Three: Make Contact With the Payor

Once you understand the various terms of the existing contract or standard contract, it is time to meet with the payor's representative.

At the initial meeting with the payor representative, be prepared to discuss the changes in the terms of the agreement you are looking for. These should include:

- 1) How the practice will be reimbursed for services rendered;

- 2) How much the practice will be reimbursed for services;
- 3) Opportunities for periodic review of the reimbursement levels;
- 4) What services are covered;
- 5) The term of the agreement and the termination clauses.
- 6) Possible “special project” arrangements you may like to see with the payor.

How the practice is reimbursed for services can be as important as **how much**. Some payors like to use fee schedules that they’ve developed, and may try to insist on using those in the agreement. While this may seem like a small issue, using the payor’s fee schedule takes control away from you on adjusting fees and gives it to the payor. Other payors will propose a percentage multiple of the Medicare fee for a particular service. In theory, it may sound good to receive 130% or 140% of Medicare’s fee schedule; however, no physician needs reminding that Medicare’s fee schedule is under constant assault from Congress, and that Medicare rates are typically lower than many commercial payors. The best option for many practices, therefore, is to negotiate to be reimbursed at a multiple of your own fee schedule. This gives you more control over your fees. Review your own existing fee schedule and make adjustments before meeting with the payor.

Once you have determined the best payment methodology for your practice, you need to determine what you will accept for reimbursement. Typically, the basis for reimbursement will be a specific fee for each current procedural terminology (CPT) code. Make sure you use the same CPT codes used by Medicare (resource based relative value scale (RBRVS)), which is the standard with most medical practices. There are other companies who attach different relative value scale (RVS) values to CPT codes, such as Ingenix, which is favored by some payors. However, using different RVS scales will make the process of comparing data with the payor extremely difficult, and you will probably come out worse off compared to the payor.

Step 4: The Cost of a Pound of Flesh

Generally, the fees you request should be reasonable for the services you provide. Your fee schedule, by CPT code, should reflect the maximum fee level you charge patients for specific services. Those fees should be determined by examining the market, your position in the market, the demand for your services, and the cost of services you provide. As discussed above, practices are receiving more and more pressure from fixed revenue sources in reimbursement. When working with payors, you should examine the entire mix of fees you receive and how that impacts the overall practice reimbursement, and remember that that payors are competitors that should be competing with each other. Therefore, one strategy is to look at trying to develop parity between payors in terms of what you are reimbursed for the same CPT codes.

Legal Note: Don't seek reimbursement information from physicians in your community to determine what you should charge.

When trying to determine what is reasonable to accept as reimbursement, you may be tempted to simply call colleagues at other medical practices in your community and ask what arrangements they have with the particular payor you're negotiating with. After all, they are likely your friends and colleagues, and the payor has the information in any case, since it contracts with all of you. **RESIST THE TEMPTATION!** Other physicians may be your friends and colleagues, but they are also, from a legal perspective, your competitors. Sharing price information between competitors can be viewed as the first step to price-fixing among competitors, which is unlawful under both state and federal anti-trust law. Moreover, the Federal Trade Commission, responsible for enforcing the federal anti-trust laws, has actively enforced those laws in the Rocky Mountain Region in recent years among physician groups sharing pricing information and attempting to negotiate reimbursement rates as a group. In two recent examples, the FTC entered into consent decrees (essentially official settlement agreements) with two Colorado independent practice associations (IPA's) the Boulder Valley Independent Practice Association (IPA), in 2008, and the Roaring Fork Valley Physicians IPA in 2010, to stop those physician groups from sharing pricing information among independent physician practices and engaging in collective negotiations with payors. Also, don't assume that the FTC will not set its sights on Wyoming. While the Boulder Valley IPA operated in Boulder, a fairly major metropolitan area, the Roaring Fork Valley IPA operated in Glenwood Springs, Colorado, which is not so different from many towns and cities in Wyoming. Therefore, it is clearly better to avoid sharing such information, or seeking it from others. The better course of action is to obtain such information from national or regional surveys, if possible.

Once you have established your fee structure, the next step is to consider what level of reimbursement you will accept from a payor under that fee schedule. Although the ultimate goal may be to receive full (100%) reimbursement of your fee schedule, that's probably unlikely. The proportion you accept is ultimately up to you; however, 90% of your fee schedule, if it is reasonable and you have taken care to prepare it according to the steps outlined above, is not unreasonable.

Also, payors may have different levels of flexibility on different CPT codes, so be aware of the volume of your business that is being generated by specific CPT codes. It is not uncommon for 80% of a practice's volume to be concentrated in 20% of the total number of CPT codes used in the practice. For instance, a primary care practice probably generates a significant

amount of its volume and income from CPT codes 99213, 99214, 99203, and 99204. In a surgical practice, most of the volume and income is concentrated with 10 to 15 CPT codes. If you are unable to obtain the target percentage of your fee schedule that you hoped for with the payor, consider focusing on the CPT codes you use the most. Although most plans try to keep the formulas for reimbursement simple, and would prefer not to negotiate different reimbursement percentages for different CPT codes, it is an option to suggest in negotiations. Again, the factors above need to be examined in determining what to suggest. You should also require contractual language that gives you flexibility in adjusting your fee schedule from time to time, such as every six months or annually. The payor may want to cap the percentage by which fees can be adjusted in this time period, or may want contractual language locking you in to the term of the contract. However, your goal should be obtaining the greatest flexibility for fee adjustment. The ideal situation is to be fairly reimbursed for your services without making you an outlier compared to other similar practices. Remember, in most cases, the payor has the same (or even greater options) to terminate the relationship, with or without cause, as you have. It is not advisable to be on a payor's radar screen because your reimbursement levels are unreasonable. Payors want to have preferred providers in their networks, which makes them more attractive to potential clients, and just like the providers, payors have motivations other than simply the fee schedule. Most payors are willing to work with a practice if the practice is reasonable in its requests.

While this article has focused on preparing to negotiate payor agreements, the payor's response, and the course and conduct of negotiations with the payor once that preparation and initial meeting have happened, is unpredictable. However, if you have prepared as set out above, and considered all the issues discussed above, you should be much better prepared than you would otherwise be to handle whatever surprises come your way.

Conclusion: It's In Your Hands!

As you can tell, negotiating or re-negotiating a payor agreement can be very challenging and requires a strong understanding of your practice's economics, your marketplace, the contract language and how it achieves the practice's goals. However, the best advice that can be given, at this point, is that you are not powerless in your relationship with a payor. Nor do you have to be a bully, shout or scream in order to be able to negotiate effectively. Think about your practice's goals, how those can be achieved and be willing to request specific language and commitments in payor agreements. You are entering a partnership of sorts with the payor, and the best partnerships are founded on expectations and commitments that are fair, clearly stated and understood by both sides. You therefore want as much clarity as possible in the relationship, which is documented in your payor agreement. The payor also wants (and probably needs you) as a provider to understand the relationship and wants the least amount of confusion about your respective roles and responsibilities possible. The endgame of this process is for you, as a

provider, to be compensated fairly for the services you provide and not to have payor contractual issues interfere with the patient/physician relationship. Although that is a simple goal, it is not an easy one to accomplish. However, with the preparation and forethought set out above, it is possible, and you'll be the better off for having done it.