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Best Practices in Payer Contracting

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With skyrocketing costs and declining payer reimbursements, practices are struggling with ways to increase or even hold the bottom-line. In a recent Medical Group Management Association (MGMA) survey, "maintaining physician compensation levels in an environment of declining reimbursement"[1] ranked #1 when members were asked to rate the challenges they are facing. The Center for Studying Health System Change confirms these concerns in its study that found "flat or declining fees from both public and private payers appear to be a major factor underlying declining real incomes for physicians."[2] Practices can improve their revenues through an aggressive payer contracting strategy. How?

Preparation

Negotiating new contracts with payers can seem daunting. Many practices sign every contract without determining the impact to the bottom line or administrative responsibilities. By following a few simple steps, practices can confidently sit down at the negotiation table with payers.

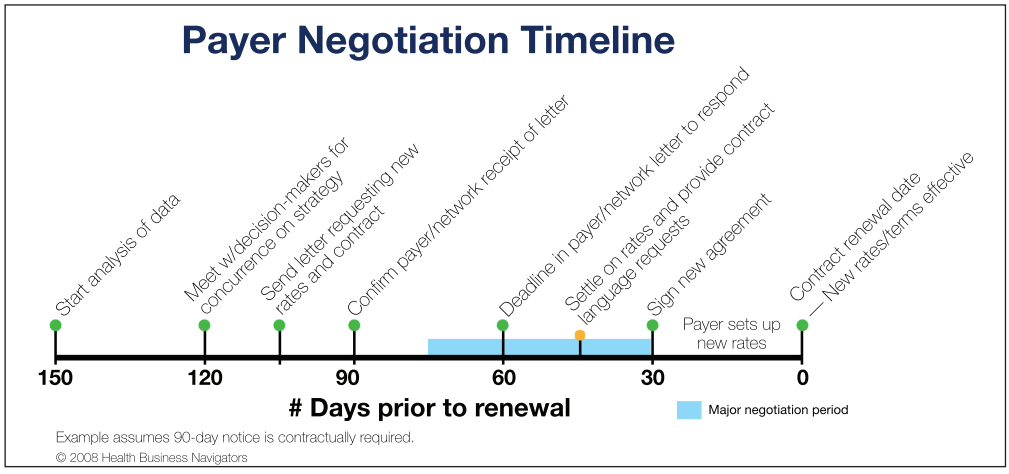
Inventory all current agreements. Create a spreadsheet identifying key information from each contract including payer/network name, anniversary, term and termination, reimbursement, notice period to renegotiate, automatic renewal, contact information for the payer/network representative, etc. Meanwhile, create a Timeline (see above illustration) for each contract to be negotiated to delineate the numerous steps necessary for successful, timely negotiations.

Leverage

Size does matter. Larger groups often have greater leverage in negotiating higher rates and contract provisions. But even a one-doctor practice should attempt to negotiate with payers. It is important to identify a negotiation strategy that is unique to practice and market. Factors might include: number of members, clinical/service outcomes, influence of employers, specialty shortages, multi-specialty group clout, payer-requested referral patterns, or a particularly poor past contract. Remember that the real trump card in any negotiation strategy is the ability to "walk."

Rate Analysis

With preparatory steps done, start the analysis. Pull a 12-month utilization report from the practice



management system that snapshots ALL (not just the top 10 or 20) procedure codes with modifiers and place of service. Include the number of units, charges, payments, current contract reimbursement rates, and cost to perform. Use this data to predict by payer what would happen if you swap your old rates for new ones at the same 12-month utilization.

Medicare's Resource Based Relative Value Scale (RBRVS) and Relative Value Unit (RVU) have become the benchmarks for many payer contracts. Having a well-defined, industry-accepted, publically available baseline has great advantages. But consider the following:

- Know the practice's best Medicare year and compare it to the year of Medicare the payer proposes.
- Medicare rates are very low and so the rates should be factored at a percentage considerably greater than 100%.
- A default calculation is necessary for anesthesia, J Codes, and procedures for which Medicare does not assign a value.
- In Medicare's quest to remain budget neutral, modifiers, like Budget Neutrality Adjuster and Geographic Price Cost Indices (GPCI), have adjusted rates downward in recent years.
- Congress gave practices relief from the proposed 10.6% cut in Medicare rates in July 2008, but there are projected decreases in Medicare rates over the next decade. Therefore, multi-year or auto-renewing contracts with rates based on "prevailing Medicare year" are not advised.

Reimbursement analysis requires careful attention to modifiers, place of service and other factors. Determine the likely loss or gain, by procedure and in aggregate, while calculating the cost to perform each procedure. For example, if new offer rates based on 145% of a certain year of Medicare RBRVS (or given conversion factor, if based on RVU) are acceptable in aggregate, but some procedures would be performed at a loss or too little margin, ask for "carve-out" rates for those few outliers to bring them into line with financial goals.

Finalizing the Deal

Once desirable rates have been agreed upon, read the substantial 15-30 page agreement before putting pen to the signature line. Know the laws of your state that affect provisions related to "insured" plans, recognizing that the "self-insured" plans accessing the agreement will not likely be subject to those laws. Spell out acceptable timely payment and filing requirements; define "assignment;" require all policies and procedures to be on the payer Web site; define Medical Necessity without plan variation; require prior written consent for ANY amendments, and more. Expect to hear "we don't negotiate." Don't accept this response. Ask for the rep's manager, know the practice deal-breakers going in and stay the course, despite these obstacles.

[1]MGMA 2008 "Medical practice today: What members have to say." June 2008.

[2]June 2006, Ha T. Tu, Paul Ginsberg. Center for Studying Health System Change

Jamon Rivera is Health Business Navigators' (HBN) Northwest Regional Director of Business Development. HBN, based in Bowling Green, KY, provides practices nationwide with tools and services related to payer contracting and credentialing. Mr. Rivera has spent the last six years on the practice management side of the industry with extensive payer negotiation experience. HBN was founded in 1999 by its CEO, Penny Noyes, who spent 18 years on the payer side of the industry. To learn more about HBN visit their web site at www.healthbusinessnavigators.com.