MANAGED CARE CONTRACTING

TOOL KIT

Greater Louisville MEDICAL SOCIETY
est. 1892

Provided By:
GLMS Physician Practice Advocacy Committee
Contract Education Task Force

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Louisville, KY 40202

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MANAGED CARE TOOLKIT

We are pleased to be able to provide you with tools to aid in contract deliberation and negotiation. These tools are available for your use and can be modified to meet the needs of your individual practice. The kit contains the following tools:

For an electronic version of the toolkit please contact:

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Stephanie Woods (stephanie.woods@glms.org)
101 W. Chestnut Street
Louisville, KY 40202
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We hope you find these tools useful in your practice

DISCLAIMER: This toolkit is not and should not be considered authoritative. It is intended solely to offer advice and operate as a tool. The persons compiling this toolkit disclaim responsibility for any adverse effects resulting directly or indirectly from the use of this toolkit, from any undetected errors, or from the reader's misunderstanding of the text.

BEYOND THE FEE SCHDULE:

PRACTICE BASED FACTORS CRITICAL TO FINANCIAL SUCCESS

To most providers, the most important part of any contract is the fee schedule. If the fee schedule is unacceptable, the clauses and language contained in the rest of the contract is irrelevant. Beyond the fee schedule, the initial focus of contract review and negotiation should be on those factors which have a financial or practical consequence and are considered unique to each practice, e.g. the use of modifiers, coding for multiple procedures, or reimbursement for nurse practitioners. Payers can be directly questioned regarding their position or process for each of the factors identified.

The following is a list of example questions that can be posed to payers. Use them as is, modify them as necessary, or develop your own list.

- How many covered lives are currently enrolled by the plan?
- How many covered lives does the plan expect to enroll over the next year? Over the next five years?
- What employers have purchased coverage?
- How long does it take to get credentialed as a participating provider?
- Who does the credentialing for the plan?
- Does the plan allow backdating of bills if the credentialing process takes longer than expected?
- Is the payment fee-for-service? If not, what is the payment method?
- Is the fee schedule a percentage of Medicare? If so what MFS year is used in the calculation of the fee schedule?
- How does the payer notify the provider prior to changes in the fee schedule? How much advance notice is given prior to the change of a fee schedule?
- What are the timely filing requirements?
- What constitutes a timely appeal process? Who reviews the appeals? How long does the appeals process take after the appeal has been submitted? If the appeal is rejected, is the reason for the rejection specified?
- Does the payer recoup overpayments or request refunds from the provider?
- What is the time limit for recovery of overpayments, either by recoupment or refund requests?
- What is the payer policy on “medical necessity” and “not medically necessary”? For a procedure deemed “not medically necessary”, does a provider collect their standard fee or payer allowable from the patient?
- Does the payer require the use of hospitalists for in-patient care?
- Can the provider accept the plan for established patients only?
- Can the provider elect to participate and later close their practice to new patients with that plan without closing their practice to patients covered by other plans?
- Does the payer accept modifiers (-22, -24, -25, -26, -50)? How are the fee schedules adjusted when the modifiers are used?
- Does the payer or plan provide benefits for preventative healthcare?
- Does the plan require referrals from the PCP to specialists? Does the plan approve referrals retroactively?
- Are unlisted procedures codes (_ _ _ 99) allowed? What additional information is necessary to pay these codes?

- Does the payer use the Correct Coding Initiatives? How are multiple procedures codes? Are internal bundling edits used?
- What is the fee schedule for the use of co-surgeons or assistant surgeons?
- How does the payer handle services for non-physician providers (Pas or NPs)? Do any employer groups not cover services provided by non-physician providers?
- Does the plan require non-physician providers to be credentialed?
- Are services provided by non-physician providers paid at 100% of the fee schedule? If not, what is the fee reduction?
- What is the time limit for submission of clean claims?
- Are pre-certifications needed for any procedures? Does the pre-certification process require specific CPT codes? Are claims paid only on specific CPT codes?
- Are carve-outs allowed on the fee schedule?
- Is a separate contract needed for DME (durable medical equipment)?
- Do any of the plans offer co-pays that are a percentage of the allowable?
- How is the fee schedule established for new procedures?
- What are the in-house procedures which can be reimbursed in addition to an office visit?
- Does the plan limit the number of in-office procedures which can be performed (including laboratory testing, x-rays, mammography, etc.)

SMITH AND JONES, PSC.
Pediatric Cardiology
Medical Arts Building
Somewhere, Kentucky 40200
502-123-4567

Alpha Insurance Agency
Anywhere, KY 40200

Dear Contact:

Begin with an introduction of your practice. Include those aspects of your practice that you believe to be unique. This begins to set up arguments for better reimbursement for unique procedures.

Thank-you for contacting Smith and Jones P.S.C. regarding the opportunity to contract with your company. As you know, Smith and Jones specializes in Pediatric Cardiology. While we provide the full range of services for patients with cardiovascular disorders, we specialize in disorders of the newborn. We have been providing service since 1989 and have a referral base that includes the western portion of the Commonwealth and all of southern Indiana.

Ask for specific information. Use this opportunity to request information that will be particularly important to your practice. Focus on those key issues that may have a direct financial or practical impact on your practice. Asking focused, specific questions shows you are informed about contract issues.

To aid us in our deliberations and review of the contract, we also require the following information:

1. Attached is a list of frequently used CPT codes. Please provide us with the current fees for each of these codes. Note that there are two columns. The first column is for listing the standard fee and the second is the fee if the procedure is performed in a location other than our office.
2. Attached is a list of procedures that we consider unique to this practice and are generally not performed by other cardiology groups. Due to the complexity and/or time required to perform these procedures, we would like to carve-out these codes and discuss unique reimbursement fees for each. Would you please provide your current fees for these codes?
3. Under the assumption that all materials have been forwarded to your offices, how long does it take to complete the credentialing process? Do you credential nurse practitioners? Are nurse practitioners reimbursed at the same fee schedule as the physicians? If not, what adjustments to the fee schedule should we expect?
4. Is a separate contract required for any non-physician provider or for durable medical equipment (DME)? If so, please forward a copy of that contract to our offices.
5. Do you allow the submission of "unlisted procedure" (xxx99)? What additional information must be submitted for payment? How is the claim processed?
6. Do you accept all modifiers per the Medicare guidelines? If not, which of the following do you accept?
   -22 -24 -25 -26 -50

As an alternative, the above questions could be developed on a separate page with "fill-in-the-blanks". The questions should be phrased in practical manner with the expectation that the answers will also be practical. Avoid questions that are philosophical in nature, e.g. "Does your contract protect the doctor patient relationship?" Follow-up to be sure the issues of concern are explicitly stated in the contract.

Close on a positive note.

Thank-you for taking the time to provide this information to us. We look forward to hearing from you and working with your company to achieve a mutually beneficial contract arrangement.

Sincerely,

Enclosures

FEE SCHEDULE WORKSHEET FOR:

_____

A	B	C
CPT Code	CPT Description	Proposed Fee

CONTRACT WORKSHEET - FEE SCHEDULE COMPARISON

COMPANY: _____ YEAR: _____

A	B	C	D	E	F	G	H
CPT Code	CPT Description	Benchmark Value	Prior Year Volume	Volume Value (C x D)	Proposed Fee	Volume Value (D x F)	Percentage Value (F/C*100)

TOTAL = **TOTAL =**

Percentage by Volume (TOTAL E / TOTAL G) =

Managed Care Contracting

Negotiating Points to Be Made By the Physician

Ultimately, the physician must convince the payer that it would rather improve its fee schedule/contract terms than lose the physician's practice to the payer's network.

The physician should be completely prepared and able to show the history of the payer inadequate fee increases, if this is the case. This should be compared to increases in expense items. The physician should bring as much hard data to the negotiation as practical. The payer will typically have little or no documentation to support its claim that its fee schedule and contract terms are competitive with other insurers.

Following are some ideas that should be considered in making this argument to the payer, if they are applicable and document able in your circumstance.

- It usually helpful to start negotiations with a comprehensive list of grievances against the payer about poor payment practices, claim denials, processing errors, unreasonable paperwork requirements and other inconveniences, if applicable.

- If true, it should be emphasized that no fee increases have been received for several years and that the practice cannot continue to deliver high quality services at below market reimbursement rates.

- Fee increases, if any, have been far below the healthcare premium increases of the payer.

- Fee increases have been below CPI and the medical inflation index

- Fee increases have not kept up with operating expenses such as rent, cost of supplies, staff salaries, and staff fringe benefits.

- The entry salaries of new doctors have increased. For some specialties, doctors do not want to relocate in our area due to low reimbursement and high malpractice cost. The cost of locum tenes coverage had soared for some specialties recently.

- Malpractice rates have increased dramatically recently. There is little hope of relief for many years even if legislation is enacted on the Federal level this year.

- The practice provides exclusive services for one or more facilities and the payer has little ability to "channel" patients away from the practice

- The practice has a favorable location, so patients will be inconvenienced if the practice does not participate with the payer. The same is true for practices that maintain multiple offices for patient convenience

- The practice provides unique services that will be unavailable if the practice does not participate with the payer.

- A solo practice should point out that if the payer does not attract an adequate number of individual physicians, it has jeopardized the ability of patients to have a personal physician.

- The practice may be the dominant provider for specific disease categories

- The practice may have too many patients for payer to place with other practices. Many practices are not taking new patients: especially patients of payer's with poor payment practices, low fee schedules and unreasonable contracts.

- The practice may provide expensive, unique equipment that will not be available to patients if the practice does not participate with the payer.

- Overall reimbursement from government payers had decreased over the last 5 years. (Medicare, Medicaid, Champus, etc.)

- If the payer had increased deductibles and co-payments, the physician needs higher fees to offset the increased patient collection cost and the bad debt that results when patients can't pay high deductibles and co-payments.

- If the payer has poor payment practices, these should be presented in detail before negotiations begin. Payment delays, payment errors and excessive paperwork requirements increase processing costs for the physician and should be offset with higher fees.

- If the practice anticipates that the payer will not cooperate in improving contract terms, the practice may preemptively make this known to referring physicians, facilities where the practice provides coverage, to employers and to patients. These groups may intervene on behalf of the practice.

- With any payer that is less than 5% of the practice's revenue, a percentage of billed charges fee arrangement should be negotiated. A payer with few patients and a desire to establish a large network will not be in a position to demand more than a small percent discount from your billed charges.

- The physician needs to be compensated for the increased time and paperwork associated with the increased credentialing requirements of the payer.

- If the payer's fee schedule does not cover the doctor's expenses for some or all procedures, this should be documented to the payer.

- If the company is the lowest payer for the practice, it should be pointed out that this payer will be the easiest to terminate. It may be good strategy for you to let the payer send inadequately reimbursed procedures to your competitors.

- Frequently, the payer will pay a higher rate to non-contracted physicians than to contracted physicians. This is because a true UCR rate may be used to pay non-network doctors, while contracted doctors are paid a "forced" rate. If this is true, it should be made known to the payer that it will cost more to pay the doctor out-of-network than to pay a reasonable contracted fee increase. If the payer cannot direct patients away from the practice, in some cases the payer will

be forced by contract terms to its employer clients to pay the physician's fee in full. The physician should let the payer know that this will be the case.

- If the payer says it can't pay a higher rate than it pays to other physicians, offer to sign a non-disclosure agreement and keep it higher payment secret.

- Tell the payer that you cannot accept a lower rate than larger insurer's that pay more. Generally, the more patients a payer serves, the larger the discount the payer will think it deserves.

- If a payer has a declining number of patients, it does not deserve the discount it commanded when it had a larger market share. This is a good reason to request a fee increase.

- If the payer tries to compare your practice to other practices, that presumably are not making the demands you are making, do not engage in this discussion. If the payer is not willing to publish the fees it pays other practices, its claims about lower payments to other practices will be unsubstantiated and meaningless to your negotiation.

If the negotiation fails, don't worry, you are in an Any willing Provider state and the payer cannot exclude you and must offer you the same terms as other physicians. (However the legal meaning of "same terms" is not known nor has it been tested in the courts.)

Negotiating Tactics the Managed Care Company May Employ

The managed care company wants a large network, presumably including all local doctors and facilities, and wants to contract services at the lowest possible rate while keeping quality high. It is unlikely that the payer will grant improved contract terms and fees just for the asking unless many requests by physicians have convinced the payer that its offerings are inadequate in the local market.

The managed care company may use the following negotiating techniques in an attempt to keep its contract and your fee schedule in place:

- The payer may simply not respond to your request to negotiate better fees and contract terms.

- The payer may say that yours is the only practice that is asking for better terms; all the other doctors are apparently satisfied. And, what is so special about your practice compared to the doctors who are not asking for more?

- The payer may say that it thought that you were satisfied with its terms because you had never asked for more in the past.

- The payer may say that your timing is bad and that its future budget has already been determined. It can't do anything in the near future.

- The payer may delay negotiations until the physician terminates the managed care contract. The payer may perceive that the physician's only bargaining chip is contract termination, and may assume the physician will not terminate the contract because physicians rarely do this.

- Even if the physician terminated the contract with appropriate notice (usually 90 days,) the payer may delay negotiations until after the final termination date of the contract, hoping the physician cannot take the pressure of dealing with patients "out of network."

- The payer may agree to changes in the contract it knows will not result in increased revenue to the physician, hoping the physician will accept and not require a fee increase.

- The payer may threaten to send payments directly to the patient and convince the doctor that it will be expensive to extract the amounts paid and the balance of the bill from the patient.

- The payer may threaten to notify the media, employers, facilities and referring doctors that the physician is being unreasonable in not participating in the payer's health plans.

- The payer may say it has a single fee schedule applicable to all doctors and cannot negotiate individually.

- The payer may say it is already paying you its highest rate and won't go higher for you. It probably won't be able to prove this to you if this information is not public ally available.

Procedure to Renegotiate Managed Care Contracts

I. Understand Your Business

Step 1

Locate all of the practice's managed care contracts, provider manuals and fee schedules.

Step 2

Analyze 4 weeks of accounts to determine:

a. Are the correct amounts being collected per the contracted fee schedules?
b. Is the staff writing off amounts not subject to contractual discounts*. (non-contracted over-UCR amounts, deductibles, co-payments, etc)

Step 3

Determine the gross collection ratio for each contracted payer. Divide the total billing of each payer into the total collections for a representative time period (3 months – 1 year.) A more sophisticated method would be to find the actual fees received for each CPT code billed.

$$\text{gross collection ratio} = \frac{\text{total collections}}{\text{total billing}}$$

Step 4

For each payer, determine if there are any extra costs to do business with the payer above and beyond filing a claim and receiving prompt payment. This may include staff time to obtain referrals and authorizations, refiling lost claims, refiling improperly paid claims, frequent appeals, time lost due to untimely payment and bad debt associated with large deductibles and co-payments imposed by the payer.

Step 5

Deduct costs from Step 4 from the receipts calculated in Step 3. This provides better insight into the "profitability" of a contract.

Step 6

Using either gross collection ratio or contractual allowances on individual procedures construct a spreadsheet to compare the payer fee schedules.

For example:

* Some practices, in order to attract patients who are "network shopping" agree to discounts with payer's with which they are not contracted. Also, with all the potential confusion associated with networks with similar names, "silent PPO's", repricers, out-of-network negotiators and third party administrators, office staff frequently erroneously write off amounts unwittingly.

Payer	**Gross Collection Ratio**	**% of Non-Government Receipts**
Blue	38%	32%
Red	46%	8%
Green	63%	2%
Purple	51%	15%

Step 7

Examine the spreadsheet to determine which payer's do not have acceptable fee schedules. The lower the gross collection ratio, the poorer the reimbursement.

Step 8

Determine if there are any actions the practice could take to increase the reimbursement of the lowest paying payer's. Make sure there are no weaknesses in your collection activities before asking for increased reimbursement. For example one could file electronically through a clearing house, file directly through the payer's web site, collect co-payments and deductibles up front to minimize bad debt, meet with the payer provider representatives to resolve claims issue, etc.

Step 9

For the low paying payer's, determine if failure to adhere to contract terms has reduced reimbursement; for example, not paying for modifiers if payment for modifiers is specifically required by the contract. If this is the case, the payer should be challenged to pay correctly and pay for past discrepancies, with interest.

Step 10

Prepare a list of grievances, if any, with the specifics of the payer's contractual breeches, unacceptable payment policies and failures of its payment systems.

II. Begin the Negotiations!

Step 11

If areas of concern are uncovered in Steps 9 and 10, send a list of these problems to the payer with a deadline for responding favorably to your correspondence. All contractual and procedural issues should be addressed before negotiating the fee schedule.

Step 12

If you determine that the payer's fee schedule is below the level desired and positive responses to Steps 9-11 will not bring payment up to requirements, contact the payer with a request for an increase in the fee schedule. The request should include the past 5 or 10 years of fee schedule increases from the payer, if any, and perhaps a few basic reasons why an increase is needed. Set a reasonable deadline for the payer's response. The deadline should be before the notification period required to terminate the contract. If the payer agrees to a reasonable increase get the offer in writing and, if necessary work on the terms of new contract that will be in effect at the end of the current contract period. Congratulations on the fee increase. If not, proceed to Step 13.

Step 13

It may take many months to correspond and meet with the payer before favorable terms are negotiated. And, your practice may be working on 5-10 different payer negotiations simultaneously. So, you should establish a file for each payer along with a tickler system to keep track of progress or lack thereof. Time is on the side of the payer, so it will be up to you to drive the process to completion. The payer may be negotiating with hundreds of healthcare providers, and may not consider your situation a priority.

Step 14

If the payer stalls, does not respond, or responds with a zero offer, you must consider your options to advance the process. There are a number of techniques that you may use depending on the size of your practice, your market power and your perceived value to the payer. These concepts are covered in a related document.

Step 15

Should the payer not respond favorably, options include:

a. continue the contract at current reimbursement;
b. develop plans for further negotiation or market position;
c. terminate the contract.

Step 16

If you decide to continue the process after an unfavorable response from the payer and are willing to risk a loss of patients, formally notify the payer that you are terminating the contract at the end of the required notification period (usually 90 days). The payer's policy may be to consider serious negotiation only in cases where it perceives a real possibility that providers will leave its network. There is the possibility that you will receive no response from the payer or that the payer will not disagree with your departure from its network. You should be prepared to invoke a contingency plan, notifying patients, referring doctors, affiliated hospitals, employers and the press, if necessary, about your contract termination.

Step 17

The payer may wait until near or after the last day of the contract and then try to open negotiations. You may be asked to honor the existing contract terms and fee schedule with a verbal agreement or a "letter of intent." You must determine if this is a ploy to delay action until the payer works itself into a stronger bargaining position. It may be wise to judge the payer's future actions by its past history. If you decide to continue to negotiate under an informal agreement, limit the agreement to a short well-defined, time period.

Step 18

At this point, the contract is terminated and the payer is still willing to talk about getting you back in the network, or you are working under a temporary "contract extension."

This maybe where the first serious negotiation by the payer takes place. If the payer didn't want your practice's participation in its network, you would not have gotten to this point. Likewise, if this payer were not important to you, you would have already walked away from the contract.

Step 19

This is the point of no return! Let's hope all the members of your practice are behind you, no matter how the contract negotiation turns out. If the payer finally agrees to your terms or a compromise is made, make notes as to how the process can be improved next time.

Step 20

The payer did not relent and you are out of network. If you ever expect to get the payer's patients back at a higher rate in the future, you should make a plan to do so now. You should monitor the actions of this payer in the local market. At some point, you may be in a better position to negotiate more favorable terms. Perhaps this payer is in the process of losing many providers other than you, and will change its strategy to include better terms for providers.