

ACG GI Practice Toolbox

The Nuts and Bolts of Negotiating an Insurance Contract

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INTRODUCTION:

Payer contracts are an important source of practice revenue and should be periodically evaluated. Changes in the cost of living, state or federal statutes and government regulations can render our contracts outdated. Contracts with automatic renewals can leave us unaware that our reimbursement rates are not keeping up with the market.. Whatever the size of your practice may be, this summary should come handy for solo, small, and large GI practices. The goal is to help prepare you for the annual review of your contracts, in order to maximize and maintain correct and timely payments.

OVERVIEW:

While large health plans have the built-in advantage of legal, financial and analytic resources, many smaller and solo, and even larger physician groups may find themselves disadvantaged in their ability to accurately portray their volume of care, quality markers, resource utilization and patient satisfaction scores. Sound knowledge about contract provisions covering claims, payment terms, medical necessity, appeal processes, notification for policy changes, credentialing requirements, termination, etc. are essential to influence your negotiation with the health plans. Familiarity with contract terms and structure can enable physicians to negotiate from a position of strength in order to achieve higher reimbursements and better payment terms.

Suggested steps for negotiating an insurance contract:

1. Review existing data
2. Analyze to determine goals and leverage
3. Negotiation with the health plan/insurance carrier

REVIEW EXISTING DATA:

Preparation for the negotiation is key. It is critical to be well informed about members served, quality measure performance of your practice, the negotiation process, definitions and requirements for contracts in your state and locality, and the status of the health plan itself. It is

a good idea to have your attorney review contracts and provide an update on state, federal and other regulations' impact on your practice. Each team member should be educated on the status of their service area, which will improve accuracy of their review. Outlining the process and using checklists to mark progress will streamline your efforts and boost success. Information gathering in core areas is the first step. These lists define this core information. Additional information may be needed depending on your reimbursement methods, terms and other contractual arrangements.

Practice service and quality data:

- CMS episode of care data with comparison² (Figures 1 & 2).
- Payer episode of care data (needs to be requested) with regional averages
- GIQUIC or other quality data (ADR, cecal intubation rate, MIPS, patient satisfaction, QRUR, etc.)
- Patient severity of illness data
- NPI value data, www.qpp.cms.gov. Your practice and competitors
- Hospital length of stay for key diagnoses with comparison.
- Medicare spending per beneficiary (MSPB)
- Market percentage by population/age/employer/hospitals

Contract basics:

- The current contract should be reviewed well in advance of the termination date.
- Review key terms and definitions for healthcare contracts.
- Identify state, local and federal regulatory changes for health insurance contracts
- Locate any state medical society updates on carriers in your region.
- Review your current policy and procedure manual to ensure compliance with contracts.

Carrier data:

- Fee schedules for all carriers
- The National Committee for Quality Assurance (NCQA) financial performance & health plan report card, www.ncqa.org/programs/hedis
- Market percentage by population/age/employer/hospitals
- Sample key employers
- The Healthcare Effectiveness Data and Information Set (HEDIS) data www.ncqa.org/programs/hedis
- The Centers for Medicare and Medicaid Services (CMS)/Medicare fee schedule
- Medical necessity definitions and procedures
- Ask colleagues for the experiences on your carriers. Identify issues.
- Ask your staff to evaluate each carrier (use a rating form) on key areas.

Financial data (A continuous review process is recommended):

- Current charge master

- Complete current fee schedule for all carriers
- Accounts receivable by carrier and product
- Denial percentages
- Billing audit results
- Cost of living allowances, national/community/healthcare/CMS/carrier employees
- Complete list of CPT codes (ACG/CMS) to determine intensive services
- Regional cost information (An example: www.fairhealthconsumer.org)

ANALYZE TO DETERMINE GOALS AND LEVERAGES

A focused review of data and discussion should be done with the intent of answering two key questions; A) What do we want to negotiate? B) What is our leverage? It is important to clearly define and prioritize your goals, but you will also need to assess the interests of the carrier and your place in the community. Choose several concrete goals and decide which is most important.

What are my goals?

Reviewing your existing contracts will identify those contracts/provisions you deem unacceptable. This will define the contract provisions and clauses that need to be negotiated. They can usually be divided into financial terms or legal terms and form the basis for your principle negotiation goals. External legal assistance is often needed if there is any confusion over legal terms. This review can also provide a model for new carrier contracts. Table 1 gives some key areas for contract review.

Table 1:

Number of days a provider has to submit a claim
Number of days the payer has to pay the claim for services
Claim denial dispute procedures
List of and scope of services covered by the payer
Fee schedule for all covered services
Notice periods for renegotiation and termination
Term of the contract and renewal options

What is my leverage/value?

Leverage is used to induce the payer to agree to your objectives. Areas of value can be used as leverage. To determine leverage, it is vital that a medical practice or group understand their strengths, weaknesses and place in the community as well as the interests and goals of the payer. A **SWOT** (**S**trengths, **W**eaknesses, **O**pportunities, **T**hreats) analysis is often done to organize thinking around these key issues. High quality, recognized brand, large market share and high satisfaction are practice strengths, but the ability to be creative and participate in shared savings plans are also things of value that can constitute leverage with the payer.

Leverage is critical to the success of your negotiation. A shared view and agreement on a negotiation's goal and priorities is critical to plan a leverage strategy. Practices can grow leverage and value by taking advantage of opportunities. These can be classified as:

1. Leverage in Numbers: A significant amount of a plan's provider panel constitutes a desirable goal and a plan will try to preserve this.
2. Geographic Advantage: Geographic holes are undesirable and makes enrolling covered lives difficult for health plans
3. No competition: This is a leverage against managed care and reduced payments
4. Quality: Utilization and outcomes data define this. Savings could be shared but must be asked for.
5. Patient Volume: This is similar to Leverage in Numbers but can also be tied to the popularity of your practice.
6. Termination: Forcing a plan to reengage after terminating a contract. This can be effective but can be damaging to trust and relationship building.

NEGOTIATION WITH THE HEALTH PLAN/INSURANCE CARRIER

After gathering and analyzing the information and setting goals, the negotiation can begin. A written plan is important so that you can remain focused on your goals. It is recommended to review negotiation tactics as a team, so that those negotiating understand their individual roles. Typical smaller office team members would be the office manager, medical director, and the executive officer but larger organizations should communicate with stakeholders in the organization, such as financial leaders, patient accounting experts, and other physicians. A contract attorney or negotiation consultant can be helpful. The payer will need to be contacted. Your carrier likely has a liaison that can facilitate setting up a meeting. A payer relations specialist or contract specialist will be part of their team. A face-to-face meeting is typical and likely several meetings may be needed. Many guides to negotiations are available but most contain similar core principles. The ACG Toolbox, *Negotiation 101: How to Get What You Want in A Negotiation*¹⁰, summarizes the negotiation process and provides worksheets to guide you.

Basic negotiation principles include:

1. Listen to the other party: Get as much information as possible about their issues.
2. Monitor your emotions: Validate the other party's emotions and avoid negative emotions.
3. Build trust: This may be difficult. Use reflective interview techniques.
4. Understand the other party: Identify their tradeoffs.
5. Be a problem solver and look for new solutions
6. Give and take: Anchor the negotiation with an offer but remember your priorities.
7. Allow the other party to save face: You may have to say "no."
8. Look at creative ways to present an offer: 2 small losses may be better than 1 large loss.

Here are lists of recognized desirable outcomes and things to avoid.

Top 10 Plums to go after⁴

1. Access to complete fee schedule information at all times.
2. Interest payments for clean claims not paid within 30 days.
3. Multiyear contracts with predefined fee schedule escalators.
4. Ability to opt out of specific benefit plans.
5. Ability to negotiate individual fee schedules that apply only to your practice.
6. Financial incentive programs that reward sound medical management.
7. Reduced or minimized referral and prior authorization requirements.
8. Advance written notification of changes to policies and procedures.
9. Online access to eligibility, benefit, and claim information.
10. Utilization of standardized credentialing/recredentialing applications.

Top 10 Deal Breakers⁴

1. The health plan's ability to amend the contract without your signature.
2. Restricted access to all applicable fee schedule information.
3. Ambiguous definition of the entities that can access the contract and discounts.
4. Inability to independently establish panel limits and practice parameters.
5. Any reference to a "most favored-nation" clause.
6. Unacceptable risk levels or risk for services you cannot manage.
7. Cumbersome or nonstandard coding/billing requirements.
8. Application of the fee schedule for noncovered services.
9. Labor intensive referral or prior authorization requirements.
10. Timely filing requirements shorter than 90 days.

FINAL EXECUTION

When coming to an agreement on contract terms, the contract will need to be carefully reviewed for accuracy. All terms should be defined and may be cataloged in an appendix. Further, members of the team should review for items important to their job functions. After each successful negotiation of a payer contract, the practice can benefit from a "debriefing session" reviewing the process to define improvements for future contract negotiations. Once both parties execute the contract, the practice organization should designate responsible personnel or departments to be familiar with the terms of the contract. The practice should monitor performance and compliance of the terms, and work on deadlines for internal review and reporting to management. It may be prudent to initiate the next cycle of review well before the current contract expires.

It is important to build a long-term relationship with the insurance carriers. You can expect to repeat this process with them through ongoing cycles of negotiation. This will help to build confidence and ultimately achieve long-term success for your practice.

Figure 1 Example of CMS episode of care cost data.

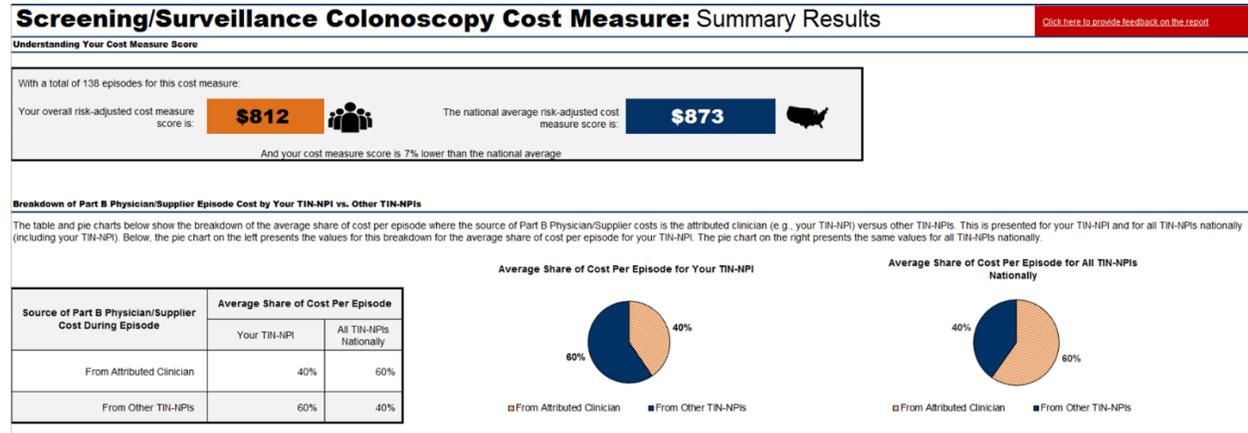
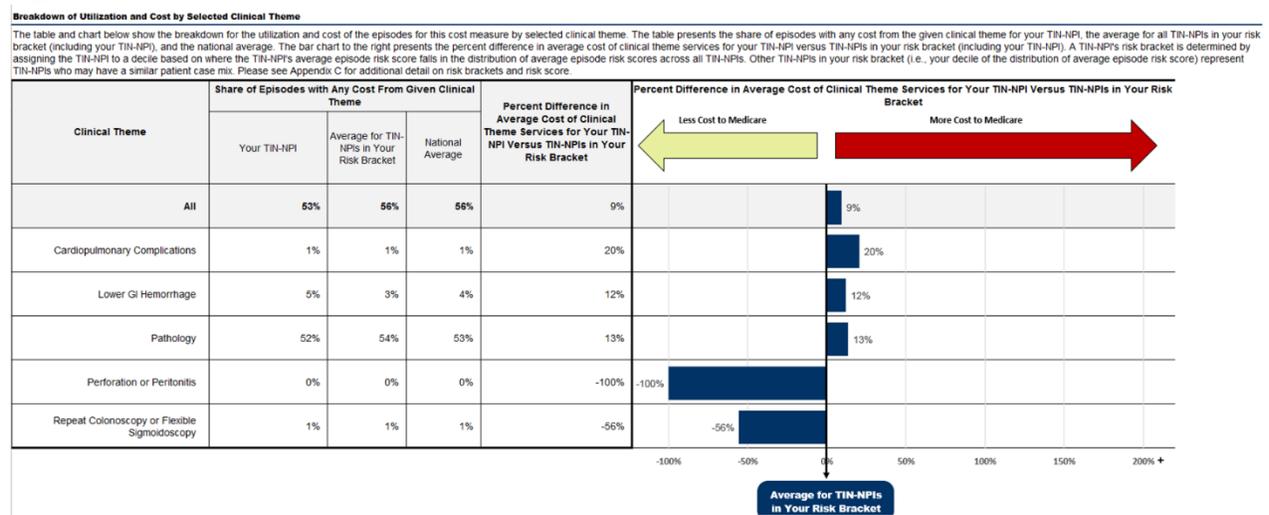


Figure 2: Example CMS provider data with comparison to others.



RESOURCES:

1. <https://www.ama-assn.org/system/files/2019-05/2019-cost-faqs.pdf>
Medicare MIPS cost category FAQ including MSPB
2. <https://data.medicare.gov/data/physician-compare>
Physician Compare datasets. The Centers for Medicare & Medicaid Services (CMS) provides official datasets for the Medicare.gov Physician Compare website to give you useful information about groups and clinicians listed on Physician Compare.
3. Kefalas C. "Negotiating Payer Contracts in the Age of Cost and Quality." Presented at: American College of Gastroenterology Annual Scientific Meeting; Oct. 5-10, 2018; Philadelphia.
4. Negotiating a Contract with a Health Plan. Christine Jones, BS and Terry Mills, Jr. MD, FAAP. Family Practice Management. November-December 2006, pg. 49-55.
5. <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/member/about-ama/pay-performance-contracts.pdf> This guide contains an appendix with a checklist of contract provisions to help you understand key contractual terms and conditions commonly used in pay-for-performance agreements and increase your ability to strategically negotiate with commercial payers.
6. <https://gi.org/2017/03/15/law-mind-its-not-all-about-that-rate-how-to-approach-negotiations-with-payers/> ACG blog article by Ann M. Bittinger, JD defining the negotiation process.
7. <https://www.ama-assn.org/practice-management/payment-delivery-models/bargaining-table-success-starts-these-common-elements> Andis Robeznieks synopsis on bargaining success.
8. Fisher, Roger, Bruce Patton, and William Ury. Getting to Yes: Negotiating Agreement Without Giving in. Rev. ed. New York: Penguin Books, 2011. A classic on coming on compromised settlements.
9. Voss, Chris., and Tahl Raz. Never Split the Difference: Negotiating As If Your Life Depended On It. First edition. New York, NY: Harper Business, an imprint of HarperCollins Publishers, 2016. The FBI hostage negotiator approach. Empowering to physicians using many of the techniques commonly used in interviews.
10. <https://gi.org/practice-management/toolbox/>, Sameer Islam, MD, MBA, FACP and Vonda Reeves, MD, MBA, FACP, Negotiation 101: How to Get What You Want In A Negotiation