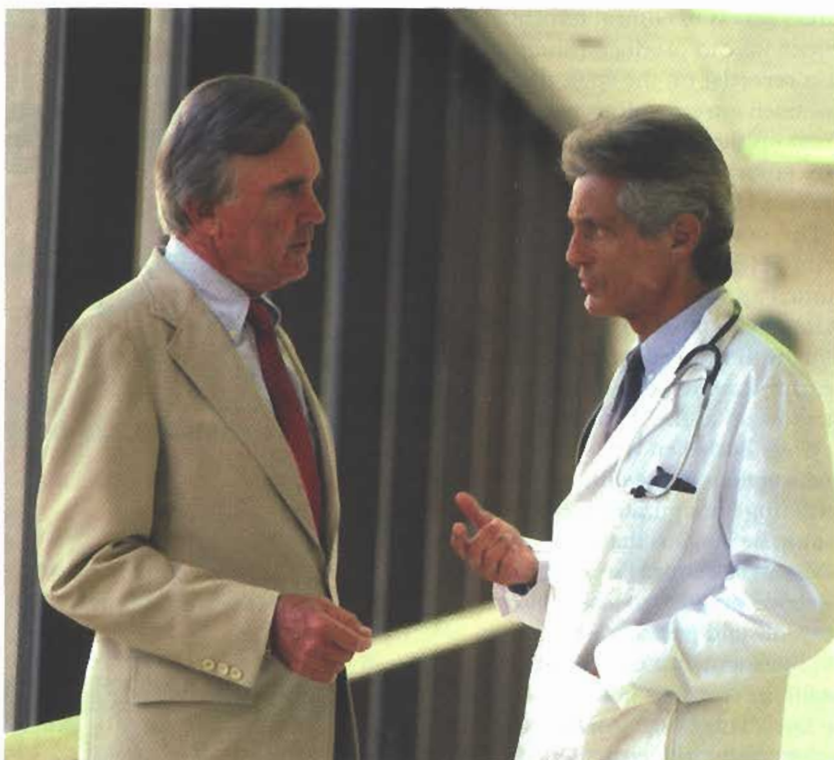
NEGOTIATE BETTER PAYER CONTRACTS

BY GREG MERTZ

YES, YOU CAN SCORE BETTER REIMBURSEMENT FOR YOUR PEDIATRIC PRACTICE.



Question: How do you guarantee you'll fail at negotiating for higher reimbursement from commercial insurance companies? Answer: Never try to negotiate in the first place.

Unfortunately, many pediatricians do (or don't do, actually) exactly that.

Instead, out of concern for their patients, they put off raising fees, accept virtually all insurance plans, and seldom engage payers in discussions about the level of reimbursement. Does this sound like you? And what is the result? You're beloved by your patients, but you often miss opportunities to collect the money you've rightfully earned for the work you do.

Granted, not all negotiations lead to success. But there are certain steps that, if taken, will improve the odds. Much depends on your local market conditions — such as the overall supply of pediatricians, the size and reputation of your group, and the number of plan members seen at your practice — wich all influence the negotiation process. Let's take a look at how these impact the outcome to improve your odds.

COLLECTING THE DATA

Collecting and reviewing data related to targeted insurance plans is key to assuring the best possible outcome. Also, your ability to assemble this information will depend heavily on the capabilities of your practice management software. Here are some reports you'll want to generate and review:

- **Participation Contract Renewal Dates.** Many payer contracts have "evergreen" clauses that delineate deadlines for sending notice to discuss the contract's renewal. Failure to notify the payer by this date means you forgo this discussion and therefore allow the contract's terms to stand for another round. While you're at it, find out which plans can change your reimbursement rates simply by sending you a notice. Keep all this information organized in a spreadsheet that allows for periodic review and updates. (See Figure 1 on page 13).
- **Charges and Payments, by Payer.** Many practices look at reimbursement in the aggregate, such as how many pennies are paid for each dollar in charges. Payment rates, though, can vary widely across payers so it's best to look at results by major insurance plan. Likely, the bulk of your business is tied to four or five major plans, so you don't need to spend excessive time looking at dozens of companies who occupy only a tiny fraction of your payer mix. You'll find this report most telling if you generate it for the most recent year, and then divide the payments received by the charges. Compare the resulting percentage for all your major plans.

Note that you shouldn't compare your reimbursement percentage to other practices in your market, or even national medians. The percentage will be driven by the level of your own practice's fee schedule and the average reimbursement level in your market; rates can vary widely by region. While some markets, such as Florida, barely exceed Medicare lev-

els, some more rural areas see rates as high as 150 percent of Medicare. The plan with the lowest percentage is an excellent target for your first efforts (see Figure 2 on page 14).

- **Market Share.** Using the report generated above, determine what percentage of your overall business each carrier reflects. The higher the percentage of your practice volume represented by a carrier, the more difficult it would be to "walk away" from participation. Therefore, concentrate on starting negotiations with the payer that represents the smallest amount of your business (or perhaps a payer that is new to the market and has little or no volume). Referring to Figure 2 again, note that, CIGNA represents only 5 percent of total business and they pay the lowest of the major commercial payers. Both of these factors make CIGNA an excellent target for your first negotiation.

FIGURE 1 — PAYER CONTRACT TRACKING REPORT

PAYER	RENEWAL DATE	NOTICE DATE	RATE CHANGE	CURRENT RATE	BASE YEAR
BCBS	7/1/08	4/1/08	Notice Only	Fee Schedule	
Aetna	10/15/08	8/15/08	Accept	115% M'care	2006
CIGNA	6/30/08	3/30/08	Notice Only	Avg 110%	2007
United	2/1/08	12/1/07	Notice Only	110% M'care	2006

WHO'S THE DECIDER? Remember that payers control where patients receive care, not you.

- **Top CPT Codes.** While many payers tie their reimbursements to some percentage of Medicare, some have their own fee schedules, developed from experience in the market or perhaps some other mysterious method. Reimbursement rates for these payers are often expressed in terms of "average," as in "our fees average 115 percent of Medicare." This is likely code for "the codes you seldom use are paid at a higher rate than the ones you use every day." Note that the Medicare reimbursement for some office visit codes increased significantly in 2007, but few commercial payers adopted the same model, instead continuing to tie their payments to Medicare rates from previous years. Most practices, especially primary care, derive the bulk of their revenue from a relatively small number of CPT codes. Pediatric practices generally garner as much as 80 percent of their reimbursements from as few as 15 or 20 codes, such as new and established office care, preventive visits, newborn care, and a few hospital codes. (While some codes, such as immunizations, may be frequently used, the revenue per code is not substantial.) Hopefully, your data system can report on dollar volume by CPT codes. If so, identify those codes that generate 75 percent or more of your charges. These are the samples that you will use to evaluate the payers.

- **Top Code Reimbursement.** The last bit of information you will need is the actual reimbursement amounts, by major payer, for your top codes. This analysis will highlight particularly low payments for codes that you use frequently. Here, you may want to include payments for services such as immunizations. One practice found that two of their larger carriers were actually paying less than the cost of the vaccine, let alone the costs associated with administration! Negotiating issues such as this are most likely to result in a positive outcome. Many payers assume — and rightly so — that if physicians aren't complaining too much, then the payment levels must be right. Consider Figure 3 on page 16. Payer B might claim that their payments "average" 115 percent, but common codes, such as established office care and routine preventive visits are in fact paid at a much lower rate.

IN SUMMARY

Negotiating with commercial insurance companies is tough, but it's the only way to get higher reimbursements from them. Here's how:

- **Gather data on targeted payers from your practice management system, including renewal dates, charges and payments, and market share.**
- **Determine your top 15 or 20 CPT codes and reimbursement levels per payer.**
- **Decide exactly what you want out of the negotiation.**
- **Talk to the right person — ideally, a contracting manager.**
- **Make sure you fully comprehend a payer's renegotiation offer.**
- **If negotiations fail, decide whether you can afford to drop the payer.**
- **Verify that any increase agreed to by the payer is enacted as promised.**

FIGURE 2 — CHARGES AND COLLECTIONS BY PAYER

PAYER	CHARGES	COLLECTIONS	COLLECTIONS %	% OF VOLUME
BCBS	$95,000	$63,500	67%	29%
Aetna	$66,000	$46,250	70%	20%
CIGNA	$16,000	$9,250	58%	5%
United	$33,000	$20,500	62%	10%
Medicaid	$72,000	$29,250	41%	22%
Others	$47,000	$34,500	73%	14%
Total	$329,000	$203,250	62%	100%

THE NEGOTIATION PROCESS

No matter how large or popular your practice, you'll need to understand that the ultimate power rests with the payer. If your demands are too aggressive they will terminate further discussions and force you to either take their offer or they'll drop your contract. It's critical to remember that payers control where patients receive care, not you.

After you have assembled the information outlined in the section above, decide on a goal for your discussions. Are you looking for an overall increase across all CPT codes? Better reimbursement on a selection of oft-used codes? Or do you perform a service in your office that is typically performed in a more expensive setting and you are looking for a special payment arrangement?

Most insurance plans have a base fee schedule that is sent to all physicians; the majority accept this offer. They do have other reimbursement schedules that offer better reimbursement, never doubt that. But few carriers will create a unique schedule just for you. This is far too complex for them to track. You might also find that what a major payer is able to do in one geographic market may not be possible in another; despite the fact that big companies are national, many policies are regional.

It's also important to understand exactly whom in the insurance company you should deal with. Starting with your local provider-relations representative is fine, but know that ultimately you'll be negotiating with a network-development or contracting manager. You will likely have to spend time getting past the local representative before you can find out the name of the manager.

So now, you've assembled your data and identified the correct individual. You're almost ready to start the negotiation process. The last preparation step is to offer a specific proposal, backed by examples from your analysis. Simply asking for more money will seldom yield positive results.

If you are seeking an overall increase, suggest a target (115 percent of 2008 Medicare) and examples of other plans that pay at, or above that level. If a payer with higher market penetration pays a higher rate, you will have an excellent chance of doing better with the smaller players.

Alternatively, if you are seeking to correct potential code-specific payment errors, show the representative examples of what is being paid now and the rate that should be paid. In many cases, if they agree, you can even negotiate for retroactive payments.

SO THEY MADE YOU AN OFFER

There are only two possible outcomes to any negotiation: The payer says no, or the payer makes you an offer. If a health plan does propose to increase your reimbursement as a result of the negotiation process, the first offer will likely be the last. This is not an absolute, but most payers do not want to engage in a lengthy process. You might, however, suggest in response to the offer that another built-in increase be included in a multi-year agreement. Example: Fees increase by 5 percent immediately but they would grow by another 2.5 percent each year in a three year contract. This set up, known as an "escalation" clause, is attractive to payers because they know you won't pester them for more money for awhile.

Once you receive the offer, take time to comprehend all the details. If the insurance company is offering a flat percentage of Medicare, determine the base year for the offer. Note that different specialties do better in different years. The year 2007 was a good year for primary care, but 2008 is a little worse given some changes in work RVUs and practice expense components. You will also want to determine whether you're being offered the above-described escalation clause. You may want to insert language such as "current-year Medicare," but there's a risk in doing this, as there could be reductions in Medicare (as is currently on the table for 2008).

If the plan offers reimbursement based on its own fee schedule,

ONE-SHOT DEAL If a health plan does propose to increase your reimbursement as a result of the negotiation process, the first offer will likely be the last.

obtain the reimbursement dollar amounts for the top codes you identified in your data-gathering reports (described above); be sure that the payment for each is acceptable.

Did you negotiate for better reimbursement on certain codes, or for a special service you plan to offer? Be sure that the proposed payments cover your expenses and compare favorably to that offered by other plans.

If, however, after all your negotiation efforts, you are told "no" to an increase, then you are left with two options:

1. Accept the current reimbursement structure, or
2. Walk away from the plan. This means that you will no longer accept their rates as payment in full and can balance bill the patient. Unfortunately you can expect that many patients will choose other physicians so they can enjoy their full benefits.

DOES NO REALLY MEAN NO?

You tried but the targeted plan said no. What should you do now? First, don't stop after one failure. Complete the process with the other payers. If one or more agree to improve your payments you may have some leverage to reopen discussions with the uncooperative plan.

Second, decide whether the patient share covered by the problem plan will have a significant negative impact on your practice if they all decide to go elsewhere. If you routinely enjoy a full schedule and patients with better insurance are having problems getting to see you then you'll suffer little financial consequence from dumping a poor payer. Let those patients

COLLECTING WHAT YOU'VE EARNED

What factors can improve your chances of successful reimbursement negotiation with a payer?

- **Practice size — If you have a large patient population, it will be difficult for all those individuals to find other practices if you dropped out; your payer will know this, and will not relish the "bad press."**
- **Multiple locations — Convenience is important. If patients can visit you in more than one office, they will be unhappy if they have to change physicians. Again, your payer will know this.**
- **Extended hours — Once again, convenience is important to satisfaction. You might even be able to negotiate for enhanced payments for later hours or weekends.**
- **Quality — While this is a new metric, many plans are beginning to track a few clinical indicators. If you perform well and can show it, you'll have an edge.**
- **Member satisfaction — A growing number of plans measure their members' satisfaction with physicians. If you get high marks, payers will want to keep you in the plan because you make them look good.**

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FIGURE 3 — REIMBURSEMENT BY PAYER- TOP CODES

CODE	DESCRIPTION	MEDICARE	PAYER A	% OF MEDICARE	PAYER B	% OF MEDICARE
99202	OV New Level 2	$55.53	$66.60	120%	$62.00	112%
99203	OV New Level 3	$81.42	$97.70	120%	$90.00	111%
99204	OV New Level 4	$124.01	$149.00	120%	$142.61	115%
99212	OV Est Level 2	$33.39	$40.00	120%	$42.00	126%
99213	OV Est Level 3	$53.49	$64.20	120%	$58.00	108%
99214	OV Est Level 4	$80.40	$96.50	120%	$92.46	115%
99382	New Prev 1-4 yr	$86.53	$104.00	120%	$91.00	105%
99392	Est Prev 1-4 yr	$71 54	$86.00	120%	$81.00	113%
99431	Initial Newborn	$47.70	$57.00	119%	$56.00	117%
99433	Normal Newborn	$25.89	$31.00	120%	$32.00	124%

fill the schedule of your competitor. The folks with better coverage will quickly fill the openings on yours.

But if that carrier covers a substantial portion of your patient panel — usually 15 percent or more — then appeal to the patients who fall under that plan to put maximum pressure on the carrier to change its stance. Pediatricians have an advantage in this, because they enjoy deep patient loyalty.

READ MORE ABOUT IT!

Visit PhysiciansPractice.com for related articles and tools about negotiating with payers to maximize reimbursements:

- Get even more tips on successful negotiation with payers. Type "Tired of Being at the Mercy of Tight-fisted Payers?" in our online Search Articles box.
- Not sure what Medicare owes you for 2008? Go to our online Tools section and download CMS' payment lookup tool and an Excel listing of 2008 RVUs.
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Send a notice to the potentially affected patients, advising them that you will no longer participate. Give a six to twelve month notice. Chances are the complaints will begin to pummel the insurance plan or the benefits office at the employer almost immediately. This really does work.

You may have less leverage — and therefore more risk — if your schedule routinely has openings or you have a badly behaving carrier that covers, say, 25 percent or more of your patients. Still, project what the loss of that revenue would do to your practice. Can you survive this drop for six months or so, until you can build up the deficit with new patients? The practice-wide belt tightening may be worth it in the end. Even if you decide you can't drop the payer outright, you can still enact a plan to slowly reduce your dependence on poor paying patients by not accepting any new patients under that plan, and ramping up your efforts to secure new clients carrying better insurance.

SOME FINAL THOUGHTS

You negotiated a better rate? Fabulous. But don't think your work is done. Even if the plan agreed to change reimbursement, make sure you know exactly when this will happen, and that it does in fact occur. Many insurance companies take months to make the changes in their data systems; in some cases, the changes never actually get made. Stay on top of this. While visiting one large practice I noted that one major payer was much lower than the others. The manager told me I had to be wrong because they had negotiated an excellent rate, tied to "current" year of Medicare. It turns out that the change was made two years earlier but remained fixed on the initial year. The practice had lost over $40,000 due to the error. While we were able to recover this, they would have lost more if they didn't actively monitor the payment levels. Payers make mistakes; keep an eye on them.

You have nothing to lose by negotiating for better payments and everything to gain. Assemble your contracts, determine when they renew, gather your data, and make contacts with the payers — starting today. ■

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