Making your case with managed care

Negotiating with insurance companies is still an option, but requires preparation and perspective.

I’m regularly contacted by ophthalmology practices and ambulatory surgical centers and asked, “Can you help us get better reimbursements,” or, “Can you help us get such-and-such a service added to our reimbursements?”

The answer is never “Yes” but instead, “Maybe.” As with everything in managed care, it depends. Circumstances of timing, local marketplace and service area conditions, and payer attitudes drive everything. I’ve negotiated contracts increasing reimbursement to levels in excess of 140% of Medicare Allowable, while in one particularly frustrating instance with a different payer I was unable to get it to move up a penny from an insulting 70% of Medicare Allowable.

So with the successes there have also been exasperating failures. To understand the whys and wherefores of negotiating and renegotiating with managed care plans, it’s essential to appreciate what has changed in recent years that has made it more challenging. Here I’ll describe both successes and failures. And then I’ll explain steps you can take to improve your practice or facility’s chances of negotiation success.

THE SETUP

How it was and how it is

In years past, practices and ASCs had the opportunity to contact payers at contract anniversary dates and discuss renewal terms, including a “bump” in reimbursements. Unfortunately far too many allowed those contracts to sit in drawers without anyone paying attention to the anniversary dates, or to the language written into those agreements signed five, six, even 10 years ago and never reviewed or renegotiated since. And the third-party payers were all too happy to benefit from allowing those rates to roll over and over.

Nowadays an administrator will give me a call and often describe the practice’s situation along these lines:

• “All of our contracts are at least five years old and nobody has looked at them,” or
• “We can’t find copies of many/most of our contracts and don’t know how old they are,” or
• “We’re not sure how much we’re supposed to be paid because the last fee schedule we can find is from 2008.”

Such statements are a “heads-up” that it’s going to be a challenge bringing that practice or facility close to where it should be reimbursement-wise, especially given the dynamics of today’s managed-care marketplace. Consider a practice that in 2009 signed a provider agreement at 80% of Medicare Allowable, and in 2014 remained there.
The owners now want an increase to at least 100% of Medicare. While that seems a reasonable request, to achieve it would mean the payer/health plan granting a 25% rate hike just to get to Medicare Allowable. The provider relations representative may say, “Oh, we can’t possibly grant such a large increase. It’s way out of budget. But we’ll move you to 84% of Medicare.”

Does he or she have any idea what it costs to run an ophthalmology practice today compared to five years ago? Or have any idea what it costs to keep current with new patient care technologies, or to meet the payroll of a growing staff, or to cover administrative and technological costs imposed by governmental rules and regulations that constantly make things harder, not easier? Truth be told, some don’t care.

The ACA doesn’t make it any easier
Since the first rumblings of the healthcare reforms that would eventually be passed as the Affordable Care Act in 2009, many payers have become increasingly stingy with increases. The sentiment I often hear is, “Physicians are expected to take less for the good of the nation’s health,” and “Physicians have to get used to doing more for less.” You can insert “facilities” for “physicians” in the previous sentences.

The full-blown implementation of the ACA and the exchanges in 2014 has made dealing with payers harder as, understandably, they try to salt away as much money as possible in anticipation of additional claims exposure to cover the historically uninsured and underinsured. They’re also worried about claims exposure for patients with pre-existing conditions that formerly were not covered, or those persons who, as a result, were “rated” in the past with higher premiums but are no longer.

Payers now are required to provide affordable insurance products to the marketplace with a promise, for what it’s worth, that in 2016 the government (i.e., the taxpay ers) will make them whole for any losses. Even assuming such financial security blanket exists, the ACA’s fundamental uncertainties are leading many payers to restrict patient access through down-sized panels. The bottom line for physicians is that managed care plans will only grow more resistant to negotiate a series of contracts with rates that exceeded what I had hoped for at the beginning of discussions. Key to that success was a generally physician-friendly negotiating posture taken by the various plan representatives in that market. For a physician group in another state facing the prospect of a significant rate reduction or loss of a key contract with a self-insured employer, I was able to negotiate a much smaller reduction that preserved an important revenue source. Even though reimbursements went down, that client was pleased with the results. But it wasn’t happen-01

Preparation is crucial
What should be your first steps in readying for negotiations?

1) First, dig into that cobweb-filled contract file drawer and prioritize your contracts into those that need immediate attention and those that don’t represent enough of your business that it makes sense to do battle over them. For the typical practice or facility, after deducting the Medicare business you’re likely going to find that five or six contracts represent the vast majority of your patients and income. (Note, if you can’t locate any contracts that you’re certain are key to the practice, contact the payers and obtain copies.)

2) After determining which contracts demand attention now and which can be left for another time or not bothered with at all, look for
the effective date of each, as well as at the dates of all amendments. If a contract is more than about four years old, find out from the payer if it makes more sense to try to amend/update that ancient document or to start fresh with a newer version.

3) Decide if you have a person in-house with the time and inclination to get down and dirty with those health plans. Are these battles you’re prepared to fight on your own? If not, you’ll need to find an experienced consultant to do battle on your behalf.

4) Finally, be absolutely certain that this is the right time to work on your contracts — you must not be pulled away by other major projects. For example, if you’re engrossed in shopping for or implementing an electronic medical records system, this is not the time also to negotiate managed-care contracts.

HOW TO IMPROVE YOUR CHANCES

Look at it from the plan’s pov

I always advise clients to give some thought to the negotiations process from the payer’s perspective. Assuming you have already identified the person at each payer/plan responsible for handling contracting of your location (and there is always someone specifically responsible), consider the following:

• Payers have no financial incentive to grant financial concessions. Any increases given to your practice or facility adversely impact a payer’s bottom line.
• The payer’s representative is thinking “What does this provider bring to our network that I can’t get from some/many/lots of others here in the local service area? What’s in it for us?”
• The payer’s contracting representative’s job is to say “No.” That’s something of an overstatement, as some really are dedicated to making things work to the benefit of all parties. But many take this “No” to the extreme until you finally give up in frustration. That payer wins by stalling, sharing data in dribs and drabs and putting up a series of roadblocks large and small.

Be environmentally aware

To have any chance of making your case, you must understand the environment in which you’re working.

1) Management should make an assessment of the local competition and of factors that differentiate your practice or facility – elements that will help you understand the local players and managed-care marketplace. For example, it’s essential to know if any significant deals exist with other local practices or ASCs, with a local hospital, with a large medical group, or a university-based practice.

2) What makes you special? What do you do particularly well? Can you document exceptional outcomes and low return-to-the-OR rates?

3) What services do you provide or what technologies do you utilize that are exclusive to your practice or facility, or are not readily available elsewhere within a 15 to 20 mile radius?

4) Can you identify contracting barriers in the past, and have you been able to eliminate or reduce the impact of such barriers?

Case study

An east coast pediatric ophthalmology practice came to me for help with a very old contract. The practice had been par with a payer for about 25 years but had not once gone back and asked for an increase. Over that time the practice accepted whatever updates the payer created as amendments.

The practice was receiving payments well below Medicare Allowable and, at a minimum, wanted to get to that benchmark. This seemed reasonable, especially as this was the only pediatric ophthalmology practice in a three-county service area, no one had ever filed a grievance against the practice, and the next nearest par pediatric ophthalmologist was across a bridge in another state.

Yet despite these factors, the plan’s representative would not even consider raising the practice’s reimbursements to the Medicare Allowable level. And the Medicare Allowable wasn’t much for a practice focused primarily on office-based services and not providing care to a more expensive, geriatric, surgically intense population. Ultimately, the practice decided to drop the contract. As much as the physicians wanted to provide care to the kids, they were not prepared to do so at a loss.

Today’s managed-care reality means that sometimes payers may leave you with no alternatives other than to continue in an unfavorable contract or to terminate. And as with the pediatric practice contract mentioned just above, termination may be the best decision.
It also important to understand these general factors giving one practice or facility “attractiveness” over another (I emphasize “general” because in the discussions above I’ve described some examples that fly in the face of what I’m about to say).

5) Solo practices generally have less bargaining power than groups. Plans prefer to sign master, group agreements encompassing several physicians under a single tax ID number rather than manage a collection of individual physician contracts each under its own tax ID number. Now this does not mean solo practices have no chance to get better deals, but it does mean a generally harder road to travel to demonstrate why the plan should grant a solo practice concessions not made to everyone else in the network.

6) Groups with multiple locations providing wide geographic coverage and greater patient access are typically more attractive than a single-location practice.

7) Multispecialty groups and single subspecialty groups are about equally attractive to payers. But often it takes educating a payer’s representative as to what makes a subspecialty special and worthy of higher compensation.

8) Practices and facilities in locales with an abundance of viable contracting options for payers (e.g., Los Angeles, New York, Dallas, etc.) generally have a harder time convincing payers that they’re needed in the network and deserve added compensation consideration as opposed to one in, say, the Oklahoma or Texas panhandles, or any rural areas. Such places don’t exactly have “a doc on every block” and thus offer payers far fewer options to providing the coverage and access needed to serve their Members.

NOW, ABOUT YOUR REQUESTS

Distinguish needs from wants

Based on my experience dealing with and working for third-party payers, I must warn you that the process from first contact to contract signing likely won’t be quick and simple. Getting to the right people will take time, and getting them interested in addressing your concerns is a challenge. Remember that you’re one of many seeking better deals. To that end it’s essential to limit your requests to what you really need, not to everything you’d like to achieve if you were on a level playing field.

For each contract under review, what is your assessment of the existing fee schedule/reimbursement terms? Specifically, which reimbursements are not acceptable and by how much? Is it E&Ms, or surgeries, or diagnostic testing or some combination? Is it all groupers in the ASC or just certain ones? Is it inadequate or no reimbursement for donor corneal tissue or glaucoma implants?

The more limited your reimbursement requests, the better your chances of getting a payer to consider them. Thus a blanket request that all reimbursements be raised by “X%” will likely be viewed quite differently than a request for an increase of “Y%” limited to four E&M and three surgery codes, or limited to two ASC groupers with a carve-out reimbursing invoice cost for donor corneal tissue.

A word of caution if you’re currently being paid a percentage of Medicare Allowable based on some previous year. Let’s say, for example, that your contract specifies “Q%” of 2009 CMS. For the services you provide most often, are you better off at that “Q%” of 2009 than you would be by asking for the same “Q%” of 2014 CMS? Carefully analyze how your key service reimbursements have trended from then to now under CMS.

So if yours is a practice heavily dependent on cataract surgery, it may not be beneficial to ask to maintain the same percentage of CMS while bringing the schedule basis year forward from 2009 to 2014 (or 2015, assuming Congress doesn’t let the annually threatened physician cuts go through). On the other hand, if yours is a subspecialty practice where key service payments have generally trended upwards in recent years, or a multi-specialty practice doing a reasonable amount of surgery other than cataract, the recent cuts in cataract may be more than offset by moving to a more current CMS basis year.

The language barrier

As to requesting changes to the contract’s language, here you really have to be selective. Since it’s essential that clients understand the hidden nuances and dangers in contracts, the reports I issue them point out every “wart” I detect. I’ll comment on each bothersome issue even if experience tells me that there is little likelihood that a payer will make changes to the language no matter how unfair. (For example, one of the most egregious is a payer reserving the right to retroactively deny eligibility after authorizing care, and
to then take back monies already paid or offset amounts against future payments.) Payer intransigence to change language that places you firmly under its thumb is a fact of life in managed care.

But there are sections of the provider agreement where a payer is more likely to offer concessions. These include the initial term, claims submission deadlines, right to “opt-out” of new product lines introduced after the contract’s effective date, the right to waive patient-owed amounts in the event of financial hardship, and, on a precious few occasions, changes to the wording on amendments.

That’s just a short list among many issues my clients have asked to change and on which we’ve achieved more balanced terms. However, with some payers it’s take-it-or-leave-it, and they’ll be very blunt.

**It is what it is**
Managed-care contracting more often than not feels as if you’re going into battle. And in a way you are – for your practice’s or facility’s financial survival. So you fight the good fight as best you’re able. Every contracting effort is different; every plan’s rules and conduct throughout the process will be different. But if you apply my three rules of managed care contracting, you’ll have a better chance of avoiding problems.

1) **No contract is better than a bad contract.**
2) **Bad contracts rarely get better with time.**
3) **Payers who won’t negotiate in good faith deal out bad contracts more often than not.**

Good luck! OM