

Contracting Strategies for Success

Introduction

This section will cover some Managed Care Contracting Strategies, which will help you structure your thoughts and bring your information to the payers. It is imperative to put a plan together before you approach the Health Plans in order to have an effective conversation.

Key Takeaways

- I. Understand how to strategize for successful contract negotiations
- II. Know your data sources and how to compile the information
- III. Understand how to use your data to prepare yourself for negotiations

Section 1.0 – Preparing your strategy

1.1 - Your strategy for contracting will rely heavily on what your goals are and those goals may be different for each payer. Keep in mind that many - if not most - payers have multiple products and plans (HMO, PPO, POS, Indemnity, Commercial Risk, Medicare Advantage, Medicaid, etc.) You may have a different goal for each plan/product. What is your goal? Is it more patients, more money, less hassle, or some combination of those? You may have several goals! When we assist providers, our first question is “What is your goal?” If you do not have a goal, then it becomes incredibly difficult to reach success. The most common goals are more money (greater reimbursement) and a greater patient volume. These are two very common goals for fee-for-service contracting. Your goals for risk-based contracting, however, might be a higher PMPM, a more defined patient base, and/or a different payment or reporting methodology. As with all strategic goals, you should think long term. Whatever your goals are, be specific and then measure your outcomes because you cannot manage something that you cannot measure. Be sure that your results meet your goals.




Examples:

Strategic long-term goal:

“An average 5% increase in reimbursement every 2 years and a 10% increase in patient volume.”

Tactical short-term goals:

“A 20% increase in clean claim payment” or “an end to pre-certification requirements for basic services.”



Be wary of multi-year contracts. It is hard to predict shifts in the Medicare Fee Schedule and Resource Based Relative Value Study (RBRVS) and you don't want your reimbursement to be tied down for too long. We like to see no more than two or three years as the longest term. We have seen contracts which are fixed to only the codes listed in the contract. If/when codes change, the contract will need to be updated!

1.2 – You should think both strategically and tactically when working on your contracts. Your strategy is the set of choices you use to achieve your overall goal, while the tactics are the specific actions used when applying those strategic choices. As you think both strategically and tactically you need to consider each health plan and their products. Again, each health plan works differently and each will have a different set of plans/products. Your goal may be working towards a 5% increase in contracted reimbursement, but you may adjust your strategy when working with a certain payer to really focus on increasing reimbursement specific to the HMO product. If your goal is an increase in reimbursement and an increase in patient volume, but the payer simply does not have more volume to send to you, your goals will not be met. You may find that it is just not worth your effort to be in every plan, every product, all the time. Keep this in mind and focus your efforts on the things that will really help your practice. Your contracting goals may be broad, but you should work to cater your strategy to each of the payers.

1.3 – When enter into negotiations, always set a high standard for your contract, the process, and your relationship with the payer representative. This strategy will provide a benchmark for your conversations with the payers and can help lead to stronger outcomes. Part of this strategy will be centered around asking for an increase. If your goal is to reach 125%, then you may start by asking for 135%. This way, the payer must work down from your original ask and they are more likely to meet you in the middle at your desired goal. Keep in mind, this can work as a disadvantage too. A payer representative may be less inclined to work with you if they feel like you are asking for too much. For this very reason, you want to be formal yet friendly when working with the payers. Sometimes contracts can feel very one sided. If that's the case, you should point this out to the payer representative. You want to have a partnership with the payer to care for their members (your patients) and you want to be paid fairly to do so. You want to work together to share data, analytics, and reporting so you can see where your practice stands when it comes to the total cost of care.

Section 2.0 - Know your data sources

2.1 – A good place to start when looking at contract rates is the Medicare Fee Schedule (MCFS). Almost all commercial contracts will have reimbursement based on the MCFS and this will give you the best starting point to analyze your contract rates. The MCFS changes from year to year and it is very important to know what year your contract is based on because it can differ by payer. For example, one of your contracts may be based on the most current year of the MCFS, but an older contract may be based on the 2010 MCFS. It is very common to have different base years across all of your contracts. Again, the rates change every year, so some years increase rates for certain services, some years do not. A payer may also calculate their reimbursement based on the Resource Based Relative Value Study (RBRVS), but it is less common. Medicare itself uses the RBRVS as its basis for rates. The year is very important for the same reasons stated above and you should be sure to confirm this information when working on your agreements.

2.2 – Another great place to obtain actionable data is your own EHR system. You want to analyze the services that you provide the most (refer back to the “bell curve” from the previous chapter). In most practices, especially in primary care, there are about 10 to 20 codes that you

provide the most. You should pay particular attention to these codes when looking at your contracts because most of your reimbursement will come from these services. When preparing yourself for negotiations, you will want to know what these codes are so you can make sure you are being reimbursed appropriately as well. You will also want to pay attention to the kinds of patients you provide services to. For example, you may see more geriatric patients in your practice. Understanding what you do, and for whom, will allow you to better craft a contract and communicate your needs to the payer.

2.3 – Being a part of the SIM Initiative has given you an advantage. You have access to some comprehensive data sources and aggregation tools that allow you to analyze trends in your patient population. It is very important to understand this data. Can you see the trends? Can you see the successful transition of your practice and its patients? Understanding data is as important as having it because the payers have it as well. They may be looking at different items, benchmarks, and tools, but we are all here for the same reason: to treat patients (members) with the highest quality of care in the most efficient and effective way possible. Use data to work with the payers, to find out what their pain points are, and how you can help them to mitigate them. A good example of a pain point for a payer would be high cost specialists. If you know you can save money by referring your patients to a more appropriate specialist, you can help the health plan and then save money in the long run. Remember, these efforts on your side should be met with fair compensation for performance, because you are helping support the health plans.

2.4 – Cost and utilization reports are some of the most important data sets to the health plans. When the payers look at the overall cost of care, they are really looking at your practice’s cost and utilization. Ask to see the payer’s information! Ask to go over their reports and compare their information to yours. For the most part, payers use claims data when evaluating your practice, which means their information is about three months old (if not six to nine months old). The reason for this is that claim “pay out” or “roll up” (phrasing differs by payer) takes time to obtain and understand. It takes time for all of the claims to come in, get processed, get paid, and finally end up on a cost report. See the example below:



Example: To get an idea of the timeline behind claims analysis, let’s look at an episode of treatment for an elderly person who may have had an acute exacerbation.

One of your elderly patients is in a minor accident and suffers a broken arm. The patient is transported to the ER, imaging and tests are preformed, and specialist services are rendered.

All of these claims (yours, specialist’s, transportation, ER, lab, and imaging) need to be sent in, processed, and paid in order to analyze the claims data for the entire episode.

Utilization data comes from claims data like that above. It may take time to process, but it is accurate information about costs. **Costs are often the most important measure to a payer and to the payer’s customer. Costs are potentially the most valuable for you in order to show how paying you more for your services will help the payer lower the overall cost of care.**

Section 3.0 – How to use your data and why it is so important

3.1 – The payers are not the only ones with good actionable data and sources. You have it as well. As stated previously, it is more important to understand the data than it is to actually have the data because the payers also have it. The data you have is typically more recent and could actually be more valuable for *tactical* reasons. You can see immediate changes; you can see your own costs and your own referral information. The payer’s data is more valuable in a *strategic* sense because it contains information on other providers and is more relevant for long term trends, as it is based on paid claims. The real value is combining all of these aspects!

1. Your understanding of data and its value.
2. Your practice information regarding your services.
3. The payer’s global information on the overall cost of care.

3.2 - When you enter into actual contract negotiations you will want to support your goals with both your data and the payer’s data. You should ask them for their information, and be sure to show them yours! The ability to compare the data from both sides is a huge benefit when negotiating your contracts, because it gives you that global view from the payer side combined with the real time data from your practice. Have a conversation with the payer about how you are helping them to achieve their goals and how you are helping to solve their pain points. These concepts are valuable to the payers when we consider that this is a mutual relationship. It is not always easy to get to the point where you can have this particular conversation. Be persistent, professional, and prepared.



Plan to hear “No” when negotiating, but treat this as a request for more information. Change your approach and work on different options, but do not be discouraged.

3.3 – We know that the integration of behavioral health services into a primary care practice can lower costs. Do not be surprised when you have to show your payer representative what we all know to be true! As is often the case, the provider community is out ahead of the payer community and you may need to show them the facts. Don’t stop there. You need to actually be paid properly and fairly. It’s not enough for a payer to agree that adding behavioral health services to your practice is valuable. You need to be paid for it. You will need to determine an acceptable rate and the way in which you will be paid. Keep these things in mind. What codes will be paid and how many? Can you simply bill office visits and if so, what diagnosis will allow for payment? Different payers will have different allowances for treatment modalities and reporting.



In contract discussions specific to behavioral health you will need to ask all of these questions:

- How do I report behavioral health services (CPT and/or ICD-10)?
- Is there a limit to the number of services I can provide in my practice?
- What happens if I exceed the allowable number of services?
- Which of your plans have behavioral health coverage and is it a patient benefit?

You want to be paid for your services, which the health plan is essentially selling to their customers. You provide integrated behavioral health services in addition to office visits, procedures, consultations, labs, etc. You help keep the payer's members healthy and therefore help cut down on cost. Can you prove your effectiveness? You can!

1. Have your clinical quality measures available.
2. Prepare your cost and utilization information.
3. Work with the payers to obtain and analyze their total cost of care data.
4. Find out who your most expensive patients are and develop a plan to best to manage those patients.

Use these tactics, along with any other actionable data, to prove your value to the health plan for their product line up. These are your talking points. Use them to have a discussion about your costs and the necessary reimbursement cover those costs. The most important thing about data is that you understand it. Your understanding of your own data and how it is relevant to your relationship as a provider within a payer's network is incredibly important.



Be transparent. Be persistent. Be determined. Be successful.

Please fill out the survey included in the link below. Tell us what you think!

Survey Link: <https://www.surveymonkey.com/r/9QR6SPV>

Chapter 3 Worksheets

There are two worksheets for Chapter 3.

- 1) This worksheet will help you work out your strategic goals for contracting with your payer by setting a SMART goal. Setting a SMART goal for your contracts will help you stay focused and measure your success when contracting.
- 2) This worksheet is designed to help you understand how to calculate your reimbursement for your contracts. In this example, you will work to calculate reimbursement for two different contracts to help you determine if the rate is acceptable for your practice.

****Worksheets attached on next page.***

Worksheet 1: SMART Goal

Setting a SMART goal for your contracts will help you clarify exactly what is required in order to achieve success. SMART is an acronym to break your goal down into 5 parts: Specific, Measurable, Achievable, Relevant, and Time-bound. The SMART goal itself becomes the overall *strategy* behind your contracts while the individual elements of the goals are the *tactics* you will use to get there.

Remember that your *strategy* is the set of choices you use to achieve your overall goal, while the *tactics* are the specific actions used when applying those strategic choices.

Below is an example of a SMART goal that can help you get started:

Strategy	Tactics	Examples
<u>S</u>pecific	<ul style="list-style-type: none"> Your goal should be clear and specific, otherwise it becomes difficult to focus your efforts. Ask yourself: <i>What do I want to accomplish?</i> 	<ul style="list-style-type: none"> Want a 5% increase in reimbursement to all available ABC Insurance products (HMO, PPO, & Indemnity)
<u>M</u>easurable	<ul style="list-style-type: none"> Your goal should be measurable so that you can manage it. Think about where you are now and then where you want to be. Ask yourself: <i>What metrics can I use to determine if my goal has been met?</i> 	<ul style="list-style-type: none"> Current ABC Insurance reimbursement is set at: <ul style="list-style-type: none"> HMO - 120% PPO - 120% Indemnity - 125% Use the Medicare Fee Schedule to calculate your reimbursement
<u>A</u>chievable	<ul style="list-style-type: none"> You must know what you need to make your goal attainable. It is important to stay motivated. Ask yourself: <i>What tools/resources do I need to accomplish my goal? Is this goal achievable?</i> 	<ul style="list-style-type: none"> Pull top 10 codes to check reimbursement for those services Have CQMs ready that show Quality improvement Review referral options to keep patients in-network
<u>R</u>elevant	<ul style="list-style-type: none"> Your goals should matter to you and they should have a positive impact on your practice. Ask yourself: <i>How is this goal going to help my practice?</i> 	<ul style="list-style-type: none"> Analyze practice data to verify that this is an important contract Focus on patient volume for ABC Insurance to justify the need for the reimbursement increase
<u>T</u>ime-bound	<ul style="list-style-type: none"> Every goal needs a timeline to help keep you on track. Set milestones to help you accomplish everything. Ask yourself: <i>When do I want this goal completed by?</i> 	<ul style="list-style-type: none"> Set a timeline to complete the new contract in three months Set a schedule to follow up with ABC Insurance every week until complete

On the next page you will find a blank matrix for you to create your own SMART goal. Use the examples above to help you structure your thoughts.

Worksheet 1 continued -

Strategy	Tactics	Actionable Items
<u>S</u> pecific		
<u>M</u> easurable		
<u>A</u> chievable		
<u>R</u> elevant		
<u>T</u> ime-bound		

Worksheet 2: Calculating Contract Reimbursement

This worksheet is designed to help you better understand how to calculate your contracted reimbursement from your various contracts. In this example, your practice is contracted with two different insurance companies: ABC Insurance and XYZ Insurance. Both of these contracts have different reimbursement rates for their products and they are both based on different years of the Medicare Fee Schedule (MCFS). All of the necessary information is included below.

Below is the contract information for both insurance companies. You should note that each insurance has HMO and PPO products and they are based on different years of the MCFS.

ABC Insurance:

- | |
|--------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • HMO – 115% • PPO – 118% • Based on 2018 MCFS |
|--------------------------------------------------------------------------------------------------------------------|

XYZ Insurance:

- | |
|--------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • HMO – 115% • PPO – 120% • Based on 2014 MCFS |
|--------------------------------------------------------------------------------------------------------------------|

2018 MCFS Extract:

Codes	Rates
99202	\$77.03
99203	\$110.78
99204	\$168.68
99212	\$45.10
99213	\$74.79
99214	\$110.31

2014 MCFS Extract:

Codes	Rates
99202	\$74.77
99203	\$108.52
99204	\$166.64
99212	\$43.88
99213	\$73.32
99214	\$108.16

Use the table below to enter the reimbursement for the E&M codes according to the contracted rates and Medicare Fee Schedules above.

You can calculate contract reimbursement using the following equation:

$$\text{Medicare Reimbursement} * \text{Contracted Rate} = \text{Contracted Reimbursement}$$

Example: \$77.03 * 115% = **\$88.58**

Codes	ABC Insurance		XYZ Insurance	
	HMO	PPO	HMO	PPO
99202	\$88.58			
99203				
99204				
99212				
99213				
99214				

Worksheet 2 – Continued

Use the chart below to help calculate the reimbursement for your actual commercial payer contracts. This chart will help keep your information organized as you analyze your top ten codes for your respective payers.

There are two extra elements in this table to help you analyze your reimbursement. There is a column for the “Actual Payment” that you received from the Health Plan, and a column for your “Charges.” You can compare your contracted reimbursement to the actual payment you are receiving to verify you are being payed correctly. Then you can compare that amount to your charges, to verify you are billing correctly.

All of this information is valuable and you can use this table below for each of your payers when you analyze your reimbursement.

Payer: _____

Example

Codes	Base Year	MCFS Rate	Contracted Rate	Contracted Reimbursement	Actual Payment	Charges
99201	2019	\$100	115%	\$115	\$115	\$200