Solid managed care contracts can facilitate patient access to comprehensive treatment and services, leading to better-coordinated and superior care delivered within more robust provider networks. This greatly enhances quality of care, improving outcomes and boosting patient satisfaction and engagement. With optimized healthcare delivery like this, all parties benefit – the provider, the payer, and, most importantly, the patient.

Unfortunately, few providers review their payer contracts carefully before signing on the dotted line. A clear grasp of the negotiation process, common pitfalls, and a keen understanding of the language in these contracts – even those already in place – can help providers leverage for better terms for their practice and reduced administrative burden for their staff, while maintaining and growing their patient base. This also reduces costs to their patients by providing them in-network care. Knowing the language can also position you much more favorably when negotiating new contracts.

Reaching an agreement with a payer about managed care requires preparation, collaboration, and compromise. In the following pages, you’ll find information to help you in your preparation for these discussions.
WHEN SHOULD YOU RENEGOTIATE

• At least every two to three years
• If administration is problematic
• If new technology has increased cost

You want to re-negotiate at least every 2-3 years. Also, renegotiate if you are seeing a lot of administrative problems like denials, claim rejections, and significant time spent on the phone with them. Also, consider renegotiating if you have adopted a new technology that has increased your cost.

Everything is negotiable; contract terms are not immutable

• You are negotiating a relationship, not a transaction
  • Meet in-person, face-to-face
  • Don’t treat payers as adversaries; rather as allies
  • Honey, not vinegar
    • Payer reps you have taken time to build a relationship with are more likely to concede to your requests for more favorable terms
• The long-term goal of any contract negotiation should be a fairer landscape for patient care and reducing administrative burden to make your and your staff’s workflow easier
• Keep an open mind for your best chance at a “win-win”
  • Solidify your own expectations for the negotiations, while appreciating the needs of the payer, as well
  • Examine your goals to ensure they’re grounded and realistic
  • Open with your ideal terms and rates, but be prepared to be receptive to reaching a middle ground and conceding to some of the payer’s more reasonable counters; these should be “give-and-take” deliberations, not “take-it-or-leave-it”
  • Both providers and payers should be prepared to compromise and collaborate to arrive at an arrangement mutually beneficial to all parties
• While both sides will have to make concessions and agree to terms that may be less than their ideals, the least any contract should cover is the cost of the care provided, but it must as well have an acceptable measure of profitability for it to be viable and sustainable for you and your institution. Know the true costs of providing care under those terms, as well as the administrative burden taken on with the agreement.
• Don’t wait until the last minute! Make sure you have plenty of time to prepare yourself by gathering necessary data (sometimes well in advance).
• These discussions should continue throughout the life of the contract; prepare to have ongoing discussions with your payers regarding the cost of care for you and your facility
  • This will aid in maintaining a positive relationship with the payer through these frequent communications, which helps during your periodic contract negotiations.
• Lastly, remember that successful negotiation means any betterment of the current situation!
WHAT DO PAYERS WANT?
When you sign a contract with the payer, know that there are 4 things they want. They want predictability, consistency, simplified administrative duties, and to save money.

**PREDICTABILITY**
Payers will limit the variability of the agreement by trying to generalize the reimbursement methodology

- Standard Fee Schedules, all-inclusive case rates, etc.

**CONSISTENCY**
Payers try to increase the consistency of the payout under an agreement by protecting themselves from high-dollar claims and claim volume spikes

- High-dollar stop loss
  
  *A stop loss clause limits the patient’s annual out-of-pocket expenses to a certain amount (deductible + co-insurance); the insurance company assumes full payment (100%) of all medical expenses after that limit is reached*

- Timely filing limits
- Electronic claim filing requirements

**ADMINISTRATIVE SIMPLIFICATION**
Roughly 10% of the total cost of a large insurance company and 15% of a smaller company go to administrative costs. Payers will try to simplify the administration required from an agreement by standardizing contract language and reimbursement arrangements.

- Medical necessity definition
- Clean claim definition
- Claim processing turnaround time
- Standard Utilization Management policies & procedures
- Appeals process
- Application of the agreement to "all lines of business"

**COST SAVINGS**

- Payers will try to control costs by:
  - Negotiation
  - Unilateral fee schedule changes across the nation
    - Reimbursement should be geographically-weighted

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Recording the dates of your last contract negotiations and any notes from those conversations can be helpful the next time you sit down with the payer’s representatives
CHART THE COURSE | Page 5
ASSESS YOUR NEEDS
DEFINE YOUR GOALS
PAYER’S NEGOTIATION RESEARCH

ASSESS THE REALITIES | Page 6
PREP: DATA = LEVERAGE
GET YOUR HOUSE IN ORDER
REVIEW ALL YOUR CONTRACTS
ASSESS YOUR PAYERS
REALISTICALLY ASSESS YOUR POSITION
COST OF CARE
MEASUREMENTS OF QUALITY

SET YOUR PRIORITIES | Page 7
PRIORITIZE YOUR PAYERS

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OTHER CONTRACT PROVISIONS | Pages 11 – 13
WHAT ARE SOME OF THE KEY CONTRACT PITFALLS?
DEALBREAKERS
DEALMAKERS
IF & WHEN TO WALK
ASSESS YOUR NEEDS

WHAT ISSUES ARE YOU HAVING?
Survey your revenue cycle staff about current payer issues. Find out what’s working and what’s not. Your staff can provide feedback at the operational level about intangibles, such as payer responsiveness, rep knowledge, the payer’s willingness to problem-solve, the payer’s consistent (or not) adherence to their own policies, and the general ease (or difficulty) of interaction/administration with that particular payer.

Do they outsource to many of their approvals for certain services, namely spine surgeries, imaging, physical therapy, etc.? Too much outsourcing can lead to fragmented communications—something that will only add to your administrative burden.

WHAT ARE YOU TRYING TO ACCOMPLISH?
Simplified administrative workflow? Getting fee schedule carve-outs on your most often reported procedure/service codes? Diversifying your level of participation with the payer via value-based care initiatives, tiered networks, Medicaid or Medicare managed care plans and expanding your patient base? Take time to determine what it is that would enhance your relationship with the payer and how that could allow you to provide better, more comprehensive care to your patients.

ARE YOUR EXPECTATIONS REALISTIC?
Does your referral base comprise a large percentage of their members, thereby affording you better leverage?

Is there substantial competition from other area practices? If so, be prepared to play hardball. You’ll need to be prepared to be able to show payers the numbers to support your argument for your preferred terms.

DEFINE YOUR GOALS

QUANTIFY YOUR NEEDS
Perform a SWOT analysis—Strengths, Weaknesses, Opportunities, and Threats

Insurance carriers are data-driven. They will do their research on a provider before they negotiate and they will have done a thorough assessment of the practice/institution before they sit down with a provider. Don’t come to the table empty-handed; gather your own data beforehand—previous years’ claims, your top procedure and service codes, etc.

DEFINE YOUR GOALS
Clearly define your goal—write down what you would consider a successful negotiation.

Determine your break-even point—what your group/facility can and can’t live without. Compromise is a given in this process, so decide beforehand what terms you’re prepared to offer as concessions for your higher-priority terms and at what point you will walk away, if certain terms aren’t met.
PREP: DATA = LEVERAGE

GET YOUR HOUSE IN ORDER
Evaluate your billing processes, analyze receivables and payments, review denials, and examine claim rejection rates. Mine claims data for the previous 1-2 years and scrutinize denials to reveal negative patterns that should be addressed. Negotiations are the ideal time to get these issues out and on the table for discussion! The more transparent communication is between you at this stage, the more likely you are to forge a profitable partnership. Ascertain whether any issues you’re having is due to the payer’s policies/processes or the issue lies in-house — are they denying claims that are coded correctly or has your billing department incorrectly applied a modifier or is unaware of the payer’s current reimbursement policy on a certain code combination? Are claims filed in a timely fashion? Are your claims “clean?” Preparing yourself fully for negotiations means verifying that you are holding up your end of the bargain and doing things correctly, as-agreed.

REVIEW YOUR CONTRACTS
Obtain the most current agreement with all attachments. Review the Provider Manual thoroughly. The contract will require your general compliance with the policies outlined in that manual, and the manual can be more informative than the contract itself. Look for specific information on their credentialing requirements; referral and prior authorization requirements; claim submission policies; coding and reimbursement policies; appeal and grievance procedures; and quality and utilization management programs. This information can help you gain a sense of how the payer’s operations are structured and can clarify the administrative burden assumed with the contract, revealing any potential staffing issues you might run into, etc. Show the manual to your group’s administrative staff for their input on how it would affect day-to-day operations at the administrative level.

ASSESS YOUR PAYERS
Ascertainment what impact the payer has/will have on your workflow. How responsive are they to problems with claims? How are they with implementation of new policies and procedures? Do they allow delegated credentialing, i.e. responsibility for credentialing is up to the provider, thus streamlining patient access to care by getting new physicians practicing faster? What percentage of your business does the payer represent?

Also, don’t forget to rank your referring physicians by frequency and type of referrals, and maintain information on the plans in which they participate. Before meeting with a particular carrier for negotiations, find out from your frequent referrers how significant that plan is in their practice.

REALISTICALLY ASSESS YOUR POSITION
Your bargaining power can be bolstered greatly by the right data. Well before negotiations begin, gather and maintain data on your top payers, top codes, the costs of care.

Look at all the payers you are contracted with. Make a spreadsheet and include:
• Volume
• Benchmark reimbursement levels
• Payment timeliness
• Payment accuracy
• Patient responsibility over the last 5 years (up or down)
• Collection success rate by payer or “write-offs” by payer
• Denials
• Timeliness of appeals
• Identify referral sources by payers
• Determine the metrics that are most important to your hospital or practice/staff
• Assign performance status based on these metrics (high, acceptable, low)

Determine your top 8 payers and top 25 codes to analyze payer financial performance. Determine the cost of care delivery versus reimbursement (see margin). Gather other costs data to justify the validity of your requests during reimbursement negotiations — implant costs, drug costs, staff costs, equipment costs, overhead, etc.

Measurements of quality are always vitally important, but especially now as the healthcare landscape is moving into value-based healthcare delivery models. Regularly and systematically survey patient satisfaction. Collect information from hospital administrators and referring physicians about the performance of your practice. Participation in national quality assessment programs, such as CMS’ Physician Quality Reporting Initiative (PQRI), will give you comparative data that you can use with payers.

COST OF CARE
Calculate the total dollars received for your work over the past 12 months and divide that by the number of visits or procedures = Average Cost per Episode of Care
• Average Cost per Patient
• Cost per Diagnosis Code
• Average Cost to the Payer (based on their current reimbursement)

Also, record patient outcomes for any procedures/services for which you plan to request carve-outs.
PRIORITIZE YOUR PAYERS

Prioritize your payers – determine which is the most important to you based on admissions, referrals, payment, etc. If you have contracts with too many payers, it can be much easier to cull, rather than to negotiate with each and every one. Don’t renegotiate all contracts at the same time. Start with your small payers and save the major players – and especially your biggest – for last, once you’ve had some successful negotiations under your belt.

THE COMMERCIAL PAYER NEGOTIATION PROCESS

- Consult with an attorney
- Send formal, written notice of intent to negotiate – Certified with Return Receipt
- All meetings should be in person
- Experience has demonstrated that it is best to speak with employees with the highest level of authority
- Set a non-negotiable deadline – 60 days is ample

The insurance company will usually be on top of when the contract is up and will usually let you know before you have to send them anything. The payer representative usually cannot approve the contract – get their boss involved, just like when buying a car the sales person has to run pricing by their manager. Stand your ground – you must be willing to walk away from the contract if the terms aren’t agreeable!

NEGOTIATION POINTS

- Your team may not be comfortable in this process
- If you are a physician clinic, the physician must be active in the negotiation process!
- If you are a hospital, you need the support of the C-suite!
- “Evergreen” contracts can be problematic
- Negotiate 2- to 3-year contracts
- Annual rate escalator
- Do not agree to reimbursement tied to a Medicare fee schedule
- Again, don’t be afraid to walk away!

You do not want the contract to be automatically renewed – healthcare is changing too rapidly! Negotiate every 2-3 years – the payer should contact you before the contract terminates. Ask for an annual rate escalator; one suggestion would be the greater of the medical consumer price index (CPI) or 5%. Don’t agree to reimbursement tied to a Medicare fee schedule unless a specific year is indicated on it, to protect against potential Medicare cuts. You want at least 130-185% above the Medicare payment – and watch for rates that dip below 130% for commonly-reported codes. That can skew the overall picture of the rates they’re offering. Again... DON’T be afraid to walk away.
HOW DO YOU PREPARE TO APPROACH A PAYER ABOUT CARVE-OUTS?

Before negotiations, perform an analysis on your top 25 procedure/service codes:
• Compare rates among payers for codes frequently used
• Compare your charges to other area physicians’ charges
• If you’re already cutting costs anywhere, be sure to show that during negotiations
• This is where knowing your cost per case of your top codes/services will be indispensable

• Be prepared to provide data
• Attempt to negotiate a “win-win” for both parties to diminish risk
• Beware of rates stated in terms of RVUs or Medicare fee schedule – frequently-billed codes could be well below average and rarely-billed codes could be several multiples above to skew the average
• Accept no less than a consistent, accessible fee schedule with clear rates, incorporated into the contract as an attachment
• Consider requesting a specific fee schedule for your top codes; again, incorporated into the contract as an attachment
• To protect carve-outs, ensure the fee schedule is exempted from any modification clause, if you’re negotiating a multi-year contract. If not exempted, ask for a notification provision so that you’re made aware of any proposed changes well before they happen.
• Be sure to determine what codes are not covered or require the use of a specific outside vendor
• Do not accept “Industry-accepted” language regarding reimbursement. This opens the door for payer discretion about reimbursement. Ask for clear, set commitments.
• Beware of the absence of language that could lead to payer discretion about reimbursement.
• Be wary of offers that assign one rate (PPO) to multiple products, i.e. Workers’ Comp, MVAs, etc. These should each have their own distinct fee schedule that is weighted to reflect the complexity of their care, as well as any state standards, if applicable.
• Accept no less than the Medicare formula for multiple procedures (modifier -51)
• Beware of language (often buried and hard to find) agreeing to matching lowest provided prices. This could be enforceable and require that you match Medicaid reimbursement rates.
• Request flat rates for in-office procedures and be prepared to show evidence of improved outcomes, lower admittance rates, lower costs to payers, easier for patients, etc.,
• Identify carve-outs with Revenue Code 278

When adding carve-outs to the contract, know that the payer is going to be concerned with the fact that they will not be able to predict the cost. However, they will likely be far more amenable to increasing reimbursements for certain CPT codes, rather than the entire contract. Do a cost and revenue analysis. Be prepared to show them data of the medical service you want to carve out (how many you do in a year, your cost, patient outcomes). Ideally, you would want a percentage of charges. Try to negotiate a win-win for both you and the insurance company, so that both of you have minimal risk. Carve outs should be identified with Revenue Code 278.
WHAT OTHER OPTIONS ARE THERE?

If a payer refuses to negotiate a carve-out, what are other ways to protect yourself from high implant costs through the contracting process? Consider the options below. Note that spine implants are subject to the same contracting methodologies as other implants, i.e. stents, pacemakers, and other ortho implants (hips, knees).

Per diem
- Request a separate spine per diem
- Determine your implant cost for all spine cases by payer from past claims
- Apply the anticipated cost increase
- Divide that cost by the number of spine cases (instrumented and non-instrumented) for that payer
- Add that amount to the requested per diem

Case rates/DRGs
- Evaluate the payer’s proposed DRG weights
- Rank the proposed DRGs by weight
- Rank the DRGs by actual cost (or estimated cost)
- Compare the proposed DRG weight to the cost to ensure proper weighting
- Negotiate weight changes to account for higher implant cost in spine DRGs
- Negotiate a higher base rate to account for higher implant cost by increasing all payments

Rank your DRG’s by actual cost and rank the payer’s proposed DRG weights. Compare the two to make sure that they are close.

Charge outliers
- Per diem – request an outlier based on charges hitting a certain threshold
- DRG – request an outlier based on charges exceeding a multiple of the DRG payment or charges exceeding a threshold plus DRG payment

Negotiate a charge outlier – you are paid a percentage above the per diem or DRG payment, if the charges exceed the payment.

Discount cap
- Propose language in the contract that limits the discount on any particular claim
- Propose language in the contract that limits the overall contractual discount or plan savings

A discount cap can be especially helpful if the payer won’t agree to a stop-loss provision.

CAPITATION AND OTHER FORMS OF SHARED RISK AND FINANCIAL INCENTIVES: HOW DO THEY COMPLICATE ANALYSIS OF YOUR REIMBURSEMENT?

- Are the capitation rates age- and sex-adjusted?
- Are they severity-adjusted?
  - i.e. weighted differently for chronic or comorbid conditions
  - If not, examine stop-loss provisions, which can help limit risk to a prespecified amount per contract year
- Will they release to you detailed information on which codes/services are covered under the capitation?
- How are the programs monitored?
- How often will they send updates on the status?
- Do they allow physician input into the development of these programs?
- Do they make staff available to assist providers with data analysis and interpretation?
- How are rates affected by co-payment and benefit plan changes?
- Do they offer employer-specific capitation rates?
- What other incentives do they offer for quality, cost-effective care or medical management?
- Carefully review the criteria for the programs to ascertain if the goals are attainable.
SHOW THE PAYER NOT ONLY HOW THEY AFFECT YOU, BUT HOW YOU AFFECT THEM

With all the data you’ve gathered in preparation for negotiations, you can of course demonstrate how the payer affects you and your group/facility, but – more importantly – you can demonstrate how you affect them:

• Have they lost or gained market share in your area?
• Does your referral base comprise a large percentage of their members?
• Demonstrate your value over other providers in your area to negotiate competitive rates
• Are you the only spine surgery care provider in your area or do you provide a service unique to your practice/institution?
• If there is substantial competition from other area practices, prepare to play hardball with payers. Definitely stress that your goal is to create a better, cost-effective healthcare experience. You’ll need to be prepared to be able to show payers the numbers.
• A strong reputation for quality and patient satisfaction can position your group/facility as indispensable to the provider panel of the payer
• Show them how your high-quality services save them (and the patient!) money
• Show what the impact to them and their members would be if the cases were performed elsewhere or if your practice/institution could not function any longer due to inadequate contracts
• Demonstrate the impact to the carrier if your group/facility were to go out-of-network

HOSPITAL-SPECIFIC ISSUES

A Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups [DRGs] for inpatient hospital services). CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, OP, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities. Contracts may have implants paid by:

• Cost plus
• Cost of implant paid upon reaching a certain cost or charge threshold
• Implant costs rolled into a case rate
• Implants paid at cost not to exceed a threshold

Also, mine claims data for 1-2 years to determine how the revenue the payer brings to your organization breaks down by inpatient versus outpatient and for each service line – maternity, diagnostic imaging, surgery, etc. If the payer makes up a significant portion of reimbursement revenue for any one service line, negotiations would impact that department much more notably.

LEVERAGE
WHAT ARE SOME OF THE KEY CONTRACT PITFALLS?

Rates and the fee schedule shouldn’t be the only things you should scrutinize and negotiate. There are other things to consider when determining your goals for the negotiations.

PAYER DEFINITIONS
Be mindful of the wording in the contract, i.e. definitions for common terms – what they mean may be different than what you mean. Make sure you understand the payer’s definitions. For example, clearly define “medical necessity” in your contract. The AMA has a great reference that you can use in defining this term, if your state’s laws and regulations don’t require a specific definition. Ensure that it’s the same for fully-funded and self-funded plans – employers and unions have no standing to define medical necessity.

As well, a clear distinction between “covered services” and “health care services” is merited, if the contract language requires you to accept the applicable fee schedule as payment in full for “health care services.” A payer’s definition of “health care services” may apply far more broadly to any services a provider supplies, and would not be limited to only the services that are covered under the applicable plan, i.e. “covered services.” Accepting this language could mean accepting their payments in full for any services you provide, regardless of their coverage status under the plan.

USUAL AND CUSTOMARY
Try to avoid “usual and customary” references – every patient and case is different.

DIFFERENT POLICIES FOR DIFFERENT PAYERS
Be sure you understand the policies of the payer you are negotiating with and do not assume. They all are different!

VAGUE OR NONSPECIFIC CLAUSES & MISSING TERMS/DEFINITIONS
Be wary of “general” provisions that aren’t patently clear. The absence of terms/provisions can be more important than the opposite. If it’s not specified, that may allow payer discretion, which will likely not be in the provider’s favor. Also, the phrase “except as otherwise indicated herein” means there is likely a hidden term or provision somewhere in the contract.

BUNDLING, “DOWN-CODING” PROTECTION
Make sure you understand the payer’s policies on down-coding and bundling. Down-coding is, from a compliance perspective, just as much of a no-no as “up-coding.” Per The National Correct Coding Initiative (NCCI) General Correct Coding Policies, Chapter 1: “Physicians must avoid downcoding. If a HCPCS/CPT code exists that describes the services performed, the physician must report this code rather than report a less comprehensive code with other codes describing the services not included in the less comprehensive code.” Insist that the payer at least recognize the rules and procedures of Medicare billing.

OFFSET OF FUTURE CLAIMS, “LOOK-BACK” PROVISION
Look at their process if they overpay you or find errors in payment. Don’t agree to offsets against future claims. Keep it simple and insist that they accept it by check in one payment – rather than leaving it up to them to keep track of and deduct bit-by-bit. Strive for parity with the carrier, so that both parties have the same period of time to seek an amendment — 60 or 90 days is typical. Furthermore, insist that you have the right to contest an amendment or modification.

ADMINISTRATION OF IMPLANT CARVE-OUTS/PASS-THROUGHS
Determine and specify up-front how these will be paid.

DEALBREAKERS
- Amending contract without your signature
- Request 60-120 days’ notice for regulatory changes with the option to terminate the agreement should the regulatory change render the agreement no longer worthwhile
- Restricted access to all applicable fee schedule info
- Ambiguous definition of the entities that can access the contract and discounts
- Inability to independently establish panel limits and practice parameters (?)
- Any reference to “most-favored-nation” clause
- Unacceptable risk levels or risk for services you cannot manage (?)
- Cumbersome or nonstandard coding/billing requirements
- Application of the fee schedule for noncovered services
- Labor-intensive referral or prior authorization requirements
- Timely filing requirements shorter than 90 days
TERM & TERMINATION CLAUSE

Don't accept language that requires a lengthy period for written notice of termination. “At least 180 days prior written notice” is a long time to be stuck in an agreement you’d rather see end. The payer likely has included language in at least one place that allows them to terminate at will and without such long lead times for written notice; insist that you’re allowed the same terms if you wish to terminate your participation. Additionally, you may be offered a contract with a multiyear initial term in combination with a termination without cause provision, which wouldn’t allow for termination of the contract during the initial term and would lock you into a multiyear term. If this isn’t favorable for your practice/institution, ask that it be limited to one year and that the termination without cause provision allow termination with a 90-day, written notice regardless of the initial term. See also ‘Negotiation Points’ on page 7 regarding multiyear contracts with an annual rate accelerator tied to a third-party economic indicator like the US Consumer Price Index (CPI).

CLEAN CLAIM DEFINITION AND STANDARD CODING/BILLING PRACTICES CONSISTENCY

Is their “clean claim” definition reasonable? In other words, does it specify that claims may be filed on generally-accepted claim forms and in accordance with standard coding and billing practices consistent with community standards? If not, consider requesting that language be added so that coding and billing requirements can be consistent across all your contracts. Special or nonstandard requirements would only serve to confuse your staff and increase the administrative burden of participating in the plan, plus it could lead to unintentional errors. Don’t accept language that expands the definition to include utilization of the health plan’s unique coding standards, if applicable, as this may result in increased claim denials or delayed payments.

SILENT PPO, AKA NON-DIRECTED PPO, VOLUNTARY PPO, WRAP-AROUND PPO, OR BLIND PPO

The American Medical Association describes a Silent PPO as the “… unauthorized and unconsented application of PPO discount rates to participating doctors by indemnity insurers and third-party bill review firms whose insureds are not participants in a PPO.” This provision will allow an insurance company, often with no notice, to rent or assign the fee schedule you have agreed to, to another insurance entity or group, with whom you haven’t negotiated a contract. Don’t accept any language alluding to this type of creative discounting. If the payer won’t strike it from your contract, at the very least insist upon written notice of these practices and that you have right of refusal. The simplest solution is to insist that the insurance logo on the patient’s insurance card match the contracted payer. Inquire if there is access to a contracting payer list so that you can ensure that only approved payers are using the negotiated discounts. If so, ask how often the list is updated and distributed to contracting providers. If the payer can provide this list and has a mechanism to update you on any changes to the list, it’s less likely to enter into “silent PPO” arrangements. Additional suspicious language to strike from the contract includes any provision allowing the payer to finagle multiple discount arrangements or fee schedules for their clients – each payer and employer group should be tied to one fee schedule.

“MOST-FAVORED-NATION” CLAUSE

This language obliges you to offer the payer most favorable (read: lowest) rates that you have negotiated with any other payer or provider network. Consider requesting that this language be stricken from the agreement completely.

ADDING NEW PRODUCTS OR PLANS

Be wary of language that leaves the payer free to add any plan they wish to you agreement at any time. There should at least be provisions that require your written consent to additional plan participation.
“LESSER OF” LANGUAGE IN PROSPECTIVE PAYMENT METHODOLOGIES
Be sure you are aware if this is specified in your contract. Essentially, if your actual charges are less than the agreed-upon DRG/per diem payment, they will pay the lesser amount.

TIMELY PAYMENT AND RECONCILIATION
If they require timely filing, there should be timely payment, as well – with specifics about concessions/interest owed for late payments. Bear in mind that payers may attempt to dictate a timely filing requirement that is different from the contracted timely filing period for self-funded plans, for which state requirements may not apply. Insist that the timely filing period be consistent among fully-insured and self-insured plans – 180 days or the state’s minimum requirement, if longer than 180 days. Your practice/facility should have a reasonable period to identify overlooked claims and be able to submit them. Again, if there is a lack of language about timely filing or payment for self-funded plans, that effectively means there is no timely payment obligation.

NONDISCRIMINATION PROVISIONS
Most contracts will contain a standard nondiscrimination clause (race, creed, religion, gender, national origin, disability, medical condition, health status, etc.). Carefully review the language to ensure that they don’t extend discrimination to a patient’s membership status with the health plan. If such a provision is found in the contract, ask that a statement be added to allow you to designate a maximum panel size or participation status (accepting new patients or closed to new patients) and it specify that such designation does not constitute discrimination per the contract.

PARTICIPATION CONSISTENT WITH PARTICIPATION STATUS WITH OTHER PAYERS
Consider requesting that any provision requiring your participation with the plan match your participation status with other payers be removed from the contract. The management of your payer mix should be at your discretion and not controlled by any one agreement. In doing so, you can avoid the payer constituting a disproportionate percentage of your group/institution.

CONTRACT CONFLICTS
Watch for language hidden in other provisions that allows another agreement or contract to prevail and request that it be removed.

PHYSICIAN EXTENDER POLICIES (PAS, ARNPS, ETC.)
If your practice uses these providers, review the health plan’s policies on their utilization, as well as their credentialing/recredentialing requirements. Also, most payers apply reduced fee schedules for physician extenders.

INDEMNIFICATION LANGUAGE
Insist on equal and mutual indemnification language (applicable to the payer and the provider). If the agreement stipulates that the provider indemnify and hold the payer harmless, you should be afforded the same. However, strike any language that holds patients harmless. If a payer or self-funded plan goes bankrupt, you still should receive payment for services previously rendered. Be sure language is built in to the agreement regarding the patient’s ultimate responsibility to pay for services rendered.

IF & WHEN TO WALK
Deciding to forgo an agreement isn’t always black and white. A contract with less than ideal terms could mean loss of patient retention, disrupting ongoing care for patients, or disruption of established referral relationships. Accepting these less than ideal terms could mean losing referrals from plans with better terms that your referring providers send your way, as well as the less-favorable plans. Examine the consequences from all viewpoints before deciding.