10 Best Practices For Payer Contracting: A Roadmap for Successful Negotiations

Steve Selbst
Healthcents, Inc.
Speaker Disclosures

• Steve Selbst is employed by a business firm that provides services related to the session topic.
• Off-label and/or investigational drug uses will not be discussed during this presentation.
Session Overview

- How to prepare, negotiate, and monitor payer contracts to successfully negotiate outcomes
  - Prepare a SWOT analysis to identify opportunities and threats to your reimbursements
  - Conduct a managed care proposal reimbursement analysis used for benchmarking, fee schedule pattern identification and business modeling
    - Evaluate in-network vs. out-of-network options and maximize your billed charges to uniform, customary & reasonable (UCR) levels.
  - Techniques for negotiating “win-win” agreements with managed care companies
  - Simple technique for monitoring claims payments and comparing to your contracted rates to insure that you are not underpaid
  - Contracts’ Language Operational Review
  - ACO’s: what are they and should I participate?

*Most importantly, make more money from your commercial payer agreements!*
Completing the Practice Management Revenue Cycle

Practice Management + Payer Contracts Analysis = Complete Revenue Cycle

- Scheduling
- Coding & Billing,
- Collections
- Cash Flow
- Are my reimbursements maximized? Should I stay in network? Are my contract terms favorable? Are my billed charges high enough?
Revenue Cycle Management

Quality / IT Reporting
Clinical Patient Trends
Cash Flow Management

Business Management Systems
Operational Business Management

Analytics

Informational

Operational

Scheduling, Coding Billing, Collections, Cash Flow

Payer Contracts Analysis and Negotiations

Should I go in network? How can I maximize my reimbursements? Are the contract terms favorable? Are my billed charges high enough? Am I paid correctly?
Question?

If we have two CPT codes, J0400 which is paid by the payer, at $175.00/service and code 99601 which is paid by the payer, at $80.00/service and J0400 is performed 520 times a year and 99601 is performed 1040 times a year and I can get a 20% increase on one or the other, but not both codes, which code should I accept the increase on to increase my revenue the most, and why?

a) Code J0400  
b) Code 99601
Trends and Directions – Managed Care Contracting

• Narrow pharmacy networks
  o Large, national chains
  o Pharmacy Benefit Managers
• Narrow Home Health Agency networks
• Downward pressure on drug reimbursement – independent providers may be locked into rates offered by nationally contracted pharmacy providers.
• Bundled payments, including all-inclusive per-diems
• Many intravenous/injectable therapies have specific medical necessity criteria in order for patient to be eligible for benefit, and require prior authorization from the payer
• Denial of coverage for “off-label” use citing therapy is experimental
• Limitations on covered services based on whether the patient is determined to be “home bound” or not
• Increased pharmacy cost sharing – cost shift to patients
• Prior authorization requirements and post-payment claim review audits for compliance and proper coding
10 Best Contracting Practices boils down to...

**PREPARE**

**NEGOTIATE**

**MONITOR**
Contracts Negotiation Process

Phase 1: Prepare
- Data Analysis
- Proposal Letter
- Make Initial Contact with Payer

Phase 2: Negotiate
- Negotiate until agreement is reached
- Analyze Counter offers

Phase 2: Continue to Negotiate
- Escalate to Senior Management
- Consider Out of Network Option

Phase 3: Monitor / Re-negotiate
- Monitor Claims
- Re-Negotiate

Negotiations Completed
• Negotiate until agreement is reached
• Analyze Counter offers
• Escalate to Senior Management
• Consider Out of Network Option
• Monitor Claims
• Re-Negotiate
10 Best Contracting Practices

**PREPARE:**

Best Practice 1:
- Evaluate top codes and figure out which ones are driving revenue

Best Practice 2:
- Benchmark against Medicare and payers to determine patterns of under reimbursement, use the “20/80” rule

Best Practice 3:
- SWOT Analysis for your payer fee schedules: Look for soft spots in the fee schedule that you can negotiate, assess your out of network options and chargemaster

Best Practice 4:
- SWOT Analysis for your company

Best Practice 5:
- Prepare highly impactful proposal letter
10 Best Contracting Practices

**NEGOTIATE:**

Best Practice 6:
- Deliver highly impactful proposal letter to a contracts manager at the payer, initial follow up and establish rapport

Best Practice 7:
- More Follow up, follow up again and again, keep the payer on the hook

Best Practice 8:
- Evaluate payer proposals and look for ways to optimize counter offers if payer does not provide a proposal, don’t take first “No” as an answer. Be ready to escalate at the right time

Best Practice 9:
- Review contract for language that affects reimbursement

**MONITOR:**

Best Practice 10:
- Monitor payments and re-negotiate when the time frame allows
## Evaluate and Benchmark

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>Modifier</th>
<th>Location</th>
<th>Payer Volume</th>
<th>Billed Charged</th>
<th>Practice Charges</th>
<th>Medicare Payment</th>
<th>Payer Rate</th>
<th>Payer Average % of Medicare</th>
<th>Revenue (Payer Rate $)</th>
<th>Regional Avg % Medicare</th>
<th>State Avg % Medicare</th>
<th>National Avg % Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>99343</td>
<td>HOME VST NEW PATIENT MOD-HI SEVERITY 45 MINUTES</td>
<td>O</td>
<td></td>
<td>2265</td>
<td>165.00</td>
<td>373,725.00</td>
<td>132.06</td>
<td>115.50</td>
<td>87.46</td>
<td>261,607.50</td>
<td>-</td>
<td>-</td>
<td>124</td>
</tr>
<tr>
<td>99348</td>
<td>HOME VST EST PT LOW-MOD SEVERITY 25 MINUTES</td>
<td>O</td>
<td></td>
<td>1137</td>
<td>107.00</td>
<td>121,659.00</td>
<td>85.90</td>
<td>74.90</td>
<td>87.19</td>
<td>85,161.30</td>
<td>119</td>
<td>138</td>
<td>138</td>
</tr>
<tr>
<td>99344</td>
<td>HOME VST NEW PATIENT HI SEVERITY 60 MINUTES</td>
<td>O</td>
<td></td>
<td>222</td>
<td>230.00</td>
<td>51,060.00</td>
<td>184.78</td>
<td>161.00</td>
<td>87.13</td>
<td>35,742.00</td>
<td>-</td>
<td>-</td>
<td>118</td>
</tr>
<tr>
<td>99347</td>
<td>HOME VST EST PT SELF LMTD/MNR 15 MINUTES</td>
<td>O</td>
<td></td>
<td>572</td>
<td>72.00</td>
<td>41,184.00</td>
<td>56.67</td>
<td>50.40</td>
<td>88.94</td>
<td>28,828.80</td>
<td>79</td>
<td>140</td>
<td>140</td>
</tr>
<tr>
<td>99345</td>
<td>HOME VST NEW PT UNSTAB/SIGNIF NEW PAIN 75 MIN</td>
<td>O</td>
<td></td>
<td>145</td>
<td>280.00</td>
<td>40,600.00</td>
<td>224.15</td>
<td>196.00</td>
<td>87.44</td>
<td>28,420.00</td>
<td>-</td>
<td>-</td>
<td>117</td>
</tr>
<tr>
<td>99349</td>
<td>HOME VST EST PT MOD-HI SEVERITY 40 MINUTES</td>
<td>O</td>
<td></td>
<td>223</td>
<td>130.00</td>
<td>28,990.00</td>
<td>130.30</td>
<td>91.00</td>
<td>69.84</td>
<td>20,293.00</td>
<td>-</td>
<td>-</td>
<td>110</td>
</tr>
<tr>
<td>99342</td>
<td>HOME VST NEW PATIENT MOD SEVERITY 30 MINUTES</td>
<td>O</td>
<td></td>
<td>97</td>
<td>101.00</td>
<td>9,797.00</td>
<td>80.82</td>
<td>70.70</td>
<td>87.48</td>
<td>6,857.90</td>
<td>-</td>
<td>-</td>
<td>127</td>
</tr>
<tr>
<td>99341</td>
<td>HOME VST NEW PATIENT LOW SEVERITY 20 MINUTES</td>
<td>O</td>
<td></td>
<td>62</td>
<td>70.00</td>
<td>4,340.00</td>
<td>56.31</td>
<td>49.00</td>
<td>87.02</td>
<td>3,038.00</td>
<td>-</td>
<td>-</td>
<td>124</td>
</tr>
</tbody>
</table>

**Totals:** 85% $469,949 139% 139% 123%

## Summary for CPT Codes with Medicare Rates and Payer Rates

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer Average as % of Medicare</td>
<td>85%</td>
</tr>
<tr>
<td>Payer Weighted Avg as % of Medicare</td>
<td>87%</td>
</tr>
<tr>
<td>Payer Total Revenue</td>
<td>$469,949</td>
</tr>
<tr>
<td>Regional Avg. % of Medicare</td>
<td>139%</td>
</tr>
<tr>
<td>State Avg. % of Medicare</td>
<td>139%</td>
</tr>
<tr>
<td>National Avg. % of Medicare</td>
<td>123%</td>
</tr>
</tbody>
</table>
What should we ask for and why?

• Visit codes up 40%

• Drugs & Supplies up 20%

• So what is the effect of these changes?
### Effect of Implementing the Fee Schedule Changes...

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>Modifier</th>
<th>Location</th>
<th>Primary Payer Volume</th>
<th>Billed Charged</th>
<th>Practice Charges</th>
<th>Medicare Payment</th>
<th>Primary Payer Rate</th>
<th>Primary Payer % of Medicare</th>
<th>Primary Payer Revenue (Payer Rate * Units)</th>
<th>Comparison Payer Rate</th>
<th>Comparison Payer Revenue</th>
<th>Delta Revenue (Comparison-Primary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99343</td>
<td>HOME VST NEW PATIENT MOD-HI SEVERITY 45 MINUTES</td>
<td>O</td>
<td></td>
<td>2265</td>
<td>165.00</td>
<td>373,725.00</td>
<td>132.06</td>
<td>115.50</td>
<td>87.46</td>
<td>261,607.50</td>
<td>161.70</td>
<td>366,250.50</td>
<td>104,643.00</td>
</tr>
<tr>
<td>99348</td>
<td>HOME VISIT EST PT LOW-MOD SEVERITY 25 MINUTES</td>
<td>O</td>
<td></td>
<td>1137</td>
<td>107.00</td>
<td>121,659.00</td>
<td>85.90</td>
<td>74.90</td>
<td>87.19</td>
<td>85,161.30</td>
<td>104.86</td>
<td>119,225.82</td>
<td>34,064.52</td>
</tr>
<tr>
<td>99344</td>
<td>HOME VISIT NEW PATIENT HI SEVERITY 60 MINUTES</td>
<td>O</td>
<td></td>
<td>222</td>
<td>230.00</td>
<td>51,060.00</td>
<td>184.78</td>
<td>161.00</td>
<td>87.13</td>
<td>35,742.00</td>
<td>225.40</td>
<td>50,038.80</td>
<td>14,296.80</td>
</tr>
<tr>
<td>99347</td>
<td>HOME VISIT EST PT SEF LIMITED/MINOR 15 MINUTES</td>
<td>O</td>
<td></td>
<td>5/2</td>
<td>2.00</td>
<td>41,184.00</td>
<td>56.87</td>
<td>50.40</td>
<td>88.94</td>
<td>28,028.80</td>
<td>/0.50</td>
<td>40,360.52</td>
<td>11,331.52</td>
</tr>
<tr>
<td>99345</td>
<td>HOME VISIT NEW PT UNSTAB/SIGNIF NEW PROB 75 MIN</td>
<td>O</td>
<td></td>
<td>145</td>
<td>280.00</td>
<td>40,600.00</td>
<td>224.15</td>
<td>196.00</td>
<td>87.44</td>
<td>28,420.00</td>
<td>274.40</td>
<td>39,788.00</td>
<td>11,368.00</td>
</tr>
<tr>
<td>99349</td>
<td>HOME VISIT EST PT MOD-HI SEVERITY 40 MINUTES</td>
<td>O</td>
<td></td>
<td>223</td>
<td>130.00</td>
<td>28,990.00</td>
<td>130.30</td>
<td>91.00</td>
<td>69.84</td>
<td>20,293.00</td>
<td>127.40</td>
<td>28,410.20</td>
<td>8,117.20</td>
</tr>
<tr>
<td>99342</td>
<td>HOME VISIT NEW PATIENT MOD SEVERITY 30 MINUTES</td>
<td>O</td>
<td></td>
<td>97</td>
<td>101.00</td>
<td>9,797.00</td>
<td>80.82</td>
<td>70.70</td>
<td>87.48</td>
<td>6,857.90</td>
<td>98.98</td>
<td>9,601.06</td>
<td>2,743.16</td>
</tr>
<tr>
<td>99341</td>
<td>HOME VISIT NEW PATIENT LOW SEVERITY 20 MINUTES</td>
<td>O</td>
<td></td>
<td>62</td>
<td>70.00</td>
<td>4,340.00</td>
<td>56.31</td>
<td>49.00</td>
<td>87.02</td>
<td>3,038.00</td>
<td>68.60</td>
<td>4,253.20</td>
<td>1,215.20</td>
</tr>
</tbody>
</table>

**Primary Payer:** $469,940.50  **Comparison Payer:** $657,927.90  **Delta:** $187,987.40
### Best Practice 3: More SWOT, In vs. Out of Network Option

**Project Parameters**

| % of business this payer accounts for: | 100 |
| % of your business lost going Out of Network: | 30 |
| Out of Network administrative overhead: | 10 |
| % of your business entered into Charge Master: | 90 |
| Bill Charge Discount Rate: | 20 |
| Estimated % rate change in network: | 0 |

**Revenue Estimate for Codes entered:**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Location</th>
<th>Procedure</th>
<th>Description</th>
<th>Units</th>
<th>Bill Charge</th>
<th>Payer Rate</th>
<th>Fee For Service (Out of Network)</th>
<th>Fee For Service (In Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>99347</td>
<td>HOME VISIT EST PT SELF LIMITED/MINOR 15 MINUTES</td>
<td>572</td>
<td>$72.00</td>
<td>$50.40</td>
<td>$20,756.74</td>
<td>$28,828.80</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>99365</td>
<td>HOME VISIT NEW PATIENT HI SEVERITY 60 MINUTES</td>
<td>392</td>
<td>$217.00</td>
<td>$151.90</td>
<td>$42,872.26</td>
<td>$59,544.80</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>99344</td>
<td>HOME VISIT NEW PATIENT MOD SEVERITY 30 MINUTES</td>
<td>222</td>
<td>$230.00</td>
<td>$161.00</td>
<td>$25,734.24</td>
<td>$35,742.00</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>99342</td>
<td>HOME VISIT NEW PATIENT MOD SEVERITY 30 MINUTES</td>
<td>97</td>
<td>$101.00</td>
<td>$70.70</td>
<td>$4,937.69</td>
<td>$6,857.90</td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>99370</td>
<td>HOME VISIT NEW PATIENT LOW SEVERITY 20 MINUTES</td>
<td>5,500</td>
<td>$7.70</td>
<td>$5.39</td>
<td>$25,225.20</td>
<td>$35,035.00</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>99341</td>
<td>HOME VISIT NEW PATIENT MOD SEVERITY 45 MINUTES</td>
<td>62</td>
<td>$70.00</td>
<td>$49.00</td>
<td>$2,187.36</td>
<td>$3,038.00</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>99350</td>
<td>HOME VST NEW PATIENT MOD-HI SEVERITY 45 MINUTES</td>
<td>3,250</td>
<td>$56.00</td>
<td>$39.20</td>
<td>$91,728.00</td>
<td>$127,400.00</td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>99343</td>
<td>HOME VISIT EST PT MOD-HI SEVERITY 40 MINUTES</td>
<td>2,265</td>
<td>$165.00</td>
<td>$115.50</td>
<td>$188,357.40</td>
<td>$261,607.50</td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>99249</td>
<td>HOME VISIT EST PT MOD-HI SEVERITY 40 MINUTES</td>
<td>223</td>
<td>$130.00</td>
<td>$91.00</td>
<td>$14,610.96</td>
<td>$20,293.00</td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>99345</td>
<td>HOME VISIT NEW PT UNSTAB/SIGNIF NEW PROB 75 MIN</td>
<td>145</td>
<td>$280.00</td>
<td>$156.00</td>
<td>$20,462.40</td>
<td>$28,420.00</td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>84183</td>
<td>HOME VISIT EST PT LOW-MOD SEVERITY 25 MINUTES</td>
<td>167</td>
<td>$112.00</td>
<td>$78.40</td>
<td>$9,426.82</td>
<td>$13,092.80</td>
<td></td>
</tr>
</tbody>
</table>

**Better or Worse (·) in Network:**

- Total In Network Profit: $783,357
- Total Out of Network Profit: $564,017
- Better or Worse (·) in Network: $219,340

**Revenue uplift for codes not entered into Chargemaster:**

- $56,402
- $78,336
### Model Parameters

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesser of Bill Charge Language</td>
<td>100</td>
</tr>
<tr>
<td>Out of Network Volume</td>
<td>5</td>
</tr>
<tr>
<td>Bill Charges as % of Medicare</td>
<td>250</td>
</tr>
<tr>
<td>Out of Network Discount</td>
<td>20</td>
</tr>
</tbody>
</table>

Recalculate

### Possible Out of Network Upside of Adjustment

- **Possible Impact:** $27,457

### Carrier: 04112, Locality: 01

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Loc</th>
<th>Proc</th>
<th>Units</th>
<th>Bill Charge</th>
<th>Medicare Payment</th>
<th>Rec’d Bill Charge</th>
<th>Diff Between Rec. and Actual</th>
<th>Possible Upside</th>
<th>Current % Medicare</th>
<th>Payer Rate</th>
<th>Bill Charges Less Payer Allowable</th>
</tr>
</thead>
<tbody>
<tr>
<td>O 99347</td>
<td>572</td>
<td>$72.00</td>
<td>$56.67</td>
<td>$141.68</td>
<td>$69.68</td>
<td>$1,394.16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O 99365</td>
<td>392</td>
<td>$217.00</td>
<td>$0.00</td>
<td>$217.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O 99344</td>
<td>222</td>
<td>$230.00</td>
<td>$184.78</td>
<td>$461.95</td>
<td>$231.95</td>
<td>$2,059.72</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O 99342</td>
<td>97</td>
<td>$101.00</td>
<td>$80.82</td>
<td>$202.05</td>
<td>$101.05</td>
<td>$392.07</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O 3370</td>
<td>6.500</td>
<td>$7.70</td>
<td>$0.00</td>
<td>$7.70</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O 99341</td>
<td>62</td>
<td>$70.00</td>
<td>$56.31</td>
<td>$140.78</td>
<td>$70.78</td>
<td>$175.52</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O 99501</td>
<td>3.250</td>
<td>$56.00</td>
<td>$0.00</td>
<td>$56.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O 99343</td>
<td>2.265</td>
<td>$165.00</td>
<td>$132.06</td>
<td>$330.15</td>
<td>$165.15</td>
<td>$14,962.59</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O 99349</td>
<td>223</td>
<td>$130.00</td>
<td>$130.30</td>
<td>$325.75</td>
<td>$195.75</td>
<td>$1,746.09</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O 99345</td>
<td>145</td>
<td>$280.00</td>
<td>$224.15</td>
<td>$560.38</td>
<td>$280.38</td>
<td>$1,626.18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O 3415</td>
<td>167</td>
<td>$112.00</td>
<td>$0.00</td>
<td>$112.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O 99348</td>
<td>1.137</td>
<td>$107.00</td>
<td>$85.90</td>
<td>$214.75</td>
<td>$107.75</td>
<td>$4,900.47</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Possible Impact: $27,457

### Best Practice 3: More SWOT, Billed Charges Assessment

- **Possible Out of Network Upside of Adjustment:** $27,457
S.W.O.T. – Identify Saleable Solutions and Potential Obstacles to Getting an Increase (Best Practice 4)

**Strength**
- Location
- Size and Market Importance
- Practice Patterns
- Referral Network

**Opportunities**
- Employer Groups
- New or Specialized Services
- Value Based Contracting focused on Outcomes

**Weakness**
- Competing Practices
- Payer Reimbursement Policy
- Cost shifting to greater Patient $$ Responsibility

**Threats**
- Insurer’s Coverage Policies
- Trend to Lower Reimbursement
- National Contracting Strategies / PBMs
Putting together a highly impactful proposal letter (Best Practice 5)

• Establish relationship, why am I writing to you Mr. or Ms. Payer?

• Sell your services and address payer concerns
  ✓ What are the reasons that it is advantageous to the payer to increase our reimbursement?

• Close the “sale”, throw the hook
Establish the Relationship

- State the reason for contact and establish relationship with plan – Example of opening paragraph

I am contacting you on behalf of HOME INFUSION COMPANY to initiate a negotiation so we may join your provider network. Company epitomizes the patient-centered / wellness-focused paradigm of treatment, providing safe, efficient and effective care at a significant savings when compared to the cost of similar care provided at local hospitals. HOME INFUSION COMPANY has been doing so for the past ## years. There is high demand for our services. In the past 12 months, we provided care to #### PAYER covered lives, receiving $$ in reimbursement.
Sell your services and address payer concerns

• *Network coverage, specialties, clinical efficiency = lower cost, administrative efficiency = lower cost*

*Home infusion is a safe, cost effective alternative to hospital-based services. Bottom line, the upside for your organization of a good working relationship with Infusion Services is decreased cost with better clinical outcomes. Having HOME INFUSION COMPANY as a provider partner, serving your members, plays a role in improving medication adherence and reducing inpatient bed-days. Home infusion provides a savings of approximately $1100 per day/per patient versus traditional infusion hospital setting. Whereas hospitalization costs upwards of $1,500 to $2,500 per day, the average cost of home infusion is $150 to $200 per day (Kennedy, S. PharmD 2012, PSQH.com).*
Close the sale and “throw the hook”

• Closing statement– restate the purpose of the letter and “throw the hook”

HOME INFUSION COMPANY is committed to working with your organization, to provide safe, effective and cost efficient care to your members. To that end, HOME INFUSION COMPANY has included, in Appendix A of this letter, a proposal which commensurate with the cost and value that HOME INFUSION COMPANY provides to your members and your network.

I am confident we can come to a mutually acceptable fee schedule agreement. Your written reply to this proposal is requested by no later than DATE (2.5 weeks from date of proposal). In the meantime, if you have any questions about the company or the attached proposal, please do not hesitate to contact me.
Best Practices 6, 7 and 8

• **Best Practice 6:**
  ✓ Deliver highly impactful proposal letter to a contracts manager at the payer, initial follow up and establish rapport

• **Best Practice 7:**
  ✓ Follow up, follow up again and again, keep the payer on the hook

• **Best Practice 8:**
  ✓ Evaluate payer proposals and look for ways to optimize counter offers. If payer does not provide a proposal, don’t take first “No” as an answer. Be ready to **escalate at the right time**
Contracts Negotiation Process

Phase 1: Prepare
- Data Analysis
- Proposal Letter
- Make Initial Contact with Payer

Phase 1: Negotiate
- Negotiate until agreement is reached
- Analyze Counter offers

Phase 2: Continue to Negotiate
- Escalate to Senior Management
- Consider Out of Network Option

Phase 3: Monitor & Renegotiate
- Monitor Claims
- Re-Negotiate

Negotiations Completed
Review contract for language that affects reimbursements (Best Practice 9)

- Term and termination (90 days without cause)
- Use of non-par providers, e.g., ancillary services, anesthesia
- Timely submission of claims (90 is better, agree for 180 at the latest)
  ✓ Make sure clock restarts up rejection etc.
- Timely claims payments (30-45 days from receipt of claims)
- Claims Payment Adjustments: You are responsible vs. a withhold from future payments
- Claims Changes: Ask for changes to be agreed to in writing, e.g., recoding, reordering, claims modifications
- Retrospective review of overpayments, 90 days maximum, 180 is usual, pay them vs. payer deducts automatically
- Lesser of Language, make sure your chargemaster is set at high enough UCR levels
- Eliminate “favored nation” and / or rate parity language
- Changes to contract should trigger 30 day termination without cause, fee schedule changes should be categorized as material changes
- Performance Based Metrics: Make sure the metrics, reconciliation period, dates etc. are clear and that you have control
- *Have your legal counsel review for possible legal concerns, we recommend always having a legal counsel review your contracts*
# Best Practice 10, Monitor Claims

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>Modifier</th>
<th>Location</th>
<th>Primary Payer Volume</th>
<th>Billed Charged</th>
<th>Practice Charges</th>
<th>Medicare Payment</th>
<th>Primary Payer Rate</th>
<th>Primary Payer Average % of Medicare</th>
<th>Primary Payer Revenue (Payer Rate * Units)</th>
<th>Comparison Payer Rate</th>
<th>Comparison Payer Revenue</th>
<th>Delta Revenue (Comparison - Primary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99341</td>
<td>HOME VISIT NEW PATIENT LOW SEVERITY 20 MINUTES</td>
<td>O</td>
<td>62</td>
<td>70.00</td>
<td>4,340.00</td>
<td>56.31</td>
<td>68.60</td>
<td>121.83</td>
<td>4,253.20</td>
<td>68.60</td>
<td>4,253.20</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>99342</td>
<td>HOME VISIT NEW PATIENT MOD SEVERITY 20 MINUTES</td>
<td>O</td>
<td>97</td>
<td>101.00</td>
<td>9,797.00</td>
<td>80.82</td>
<td>98.98</td>
<td>122.47</td>
<td>9,601.06</td>
<td>88.00</td>
<td>8,536.00</td>
<td>-1,065.06</td>
<td></td>
</tr>
<tr>
<td>99343</td>
<td>HOME VST NEW PATIENT MOD-HI SEVERITY 45 MINUTES</td>
<td>O</td>
<td>2265</td>
<td>165.00</td>
<td>373,725.00</td>
<td>132.06</td>
<td>161.70</td>
<td>122.44</td>
<td>366,230.50</td>
<td>140.00</td>
<td>317,100.00</td>
<td>-49,150.50</td>
<td></td>
</tr>
<tr>
<td>99344</td>
<td>HOME VISIT NEW PATIENT HI SEVERITY 60 MINUTES</td>
<td>O</td>
<td>222</td>
<td>230.00</td>
<td>51,060.00</td>
<td>184.78</td>
<td>223.40</td>
<td>121.98</td>
<td>50,038.80</td>
<td>200.00</td>
<td>44,400.00</td>
<td>-5,638.80</td>
<td></td>
</tr>
<tr>
<td>99345</td>
<td>HOME VISIT NEW PT UNSTABL/SIGNIF NEW PROB 75 MIN</td>
<td>O</td>
<td>145</td>
<td>280.00</td>
<td>40,600.00</td>
<td>224.15</td>
<td>274.40</td>
<td>122.42</td>
<td>39,788.00</td>
<td>250.00</td>
<td>36,250.00</td>
<td>-3,530.00</td>
<td></td>
</tr>
<tr>
<td>99347</td>
<td>HOME VISIT EST PT SELF LIMITED/MINOR, 15 MINUTES</td>
<td>O</td>
<td>572</td>
<td>72.00</td>
<td>41,184.00</td>
<td>56.67</td>
<td>70.56</td>
<td>124.51</td>
<td>40,360.32</td>
<td>70.56</td>
<td>40,360.32</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>99348</td>
<td>HOME VISIT EST PT LOW-MOD SEVERITY 25 MINUTES</td>
<td>O</td>
<td>1137</td>
<td>107.00</td>
<td>121,659.00</td>
<td>85.90</td>
<td>104.86</td>
<td>122.07</td>
<td>119,225.82</td>
<td>101.00</td>
<td>114,837.00</td>
<td>-4,388.82</td>
<td></td>
</tr>
<tr>
<td>99349</td>
<td>HOME VISIT EST PT MOD-HI SEVERITY 40 MINUTES</td>
<td>O</td>
<td>223</td>
<td>130.00</td>
<td>28,990.00</td>
<td>130.30</td>
<td>127.40</td>
<td>97.77</td>
<td>28,410.20</td>
<td>127.40</td>
<td>28,410.20</td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

Primary Payer: $657,927.90  
Comparison Payer: $594,146.72  
Delta: $63,781.18
About Commercial Payer ACO’s

• ACOs are networks of providers who are held accountable for the cost and quality of the full continuum of care delivered to a group of patients.
  o Part of the Affordable Care Act
  o Intended to reduce fragmentation and improve coordination among various providers, to result in lower health care use.
• Fundamentally, 3 different Structures, next diagram...
How are ACOs Structured?

ACO Model 1
- IPA or PCP Group
- Specialty Group
- Hospital

ACO Model 2
- Multi-specialty Group
- Hospital

ACO Model 3
- Hospital Medical Staff Organization (MSO)
or
- Physician-Hospital Organization (PHO)
Should Home Infusion Providers Participate in an ACO?

Evaluate options available in your area, PPO, HMO, ACO, IPA

• Compare reimbursement in the different payment models, ACO, PPO, HMO, other
• Very Important: Evaluate bonus structures and reimbursement models
• Evaluate IT integration and patient data integration and tracking
• Capitated vs. Fee for Service?
• Go where your patients, employer groups and the money goes
• Read our article published by MGMA at http://www.healthcents.com/mgma.pdf
Trends and Directions

- Medicare moving to efficiency based quality of care metrics, less fee for service, over time
  - Expect payers to follow

- Number of ACOs and population of beneficiaries is increasing
  - About 15%-17% of US population is participating in ACO
  - IPAs and Hospital Systems moving in this direction

- Higher deductibles leads to the need for better patient collections

- Leveraging technology - telemedicine is here to stay and gaining traction with payers, may be an effective way to help manage cost in episode of care reimbursement models.

- M and A acceleration

- Paradigm shift to “E-everything”.

- Limiting/reducing referrals to other providers who are non-par (this includes facilities and ancillary providers, e.g., labs and radiology services)

- Increasing percentage of prescriptions that are generics vs. brand names, when a generic is available
Trends and Directions

• Shifting of higher percentages of reimbursement tied to incentives and value based vs. FFS

• Credentialing not leading to a contract 100% of the time

• Depending on baseline there may or may not be a first year increase.

• Increases are usually based on making an improvement of an agreed amount in each category (e.g. lowering rates of non-par referrals).

• No penalty, that we have seen on commercial payer agreements, if benchmarks are not met.
  o The provider does not get their increase for that year.

• In most cases the total increase (2.5% - 3.0%) is split among categories, for example:
  o Meeting targets on non-par referrals
  o This works for most providers because it is not an “all or nothing” deal.
10 Best Contracting Practices

**PREPARE:**

**Best Practice 1:**
- Evaluate top codes and figure out which ones are driving revenue

**Best Practice 2:**
- Benchmark against Medicare and payers to determine patterns of under reimbursement, use 20/80 rule

**Best Practice 3:**
- SWOT Analysis for your payer fee schedules: bundled payments, per diem things that make it hard for you to negotiate rates, services paid outside of facility fee

**Best Practice 4:**
- SWOT Analysis for your company

**Best Practice 5:**
- Prepare highly impactful proposal letter
NEGOTIATE:

10 Best Contracting Practices

Best Practice 6:
✓ Deliver highly impactful proposal letter to a contracts manager at the payer, initial follow up and establish rapport

Best Practice 7:
✓ More Follow up, follow up again and again, keep the payer on the hook

Best Practice 8:
✓ Evaluate payer proposals and look for ways to optimize counter offers if payer does not provide a proposal, don’t take first “No” as an answer. Be ready to escalate at the right time

Best Practice 9:
✓ Review contract for language that affects reimbursement

MONITOR:

Best Practice 10:
✓ Monitor payments and renegotiate when the time frame allows
Questions/Comments?

Steve Selbst 1-800-497-4970
Or info@healthcents.com