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Negotiating contracts: Tips for success in dealing with HMOs and PPOs

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Knowledge is power. The more you know about a health plan — whether it's a health maintenance organization or a preferred provider organization — the more successful your negotiations will be. As with any business agreement, each of the parties (you and the health plan) hopes to gain an advantage. So the time you take researching, studying and comparing rates as well as carefully assessing the terms and verbiage before signing is time well spent. This article — the first in a three-part series — addresses contracting tips that will help you leverage your power and increase your chances of negotiating an advantageous provider contract.

Tips for success in dealing with HMOs and PPOs

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The following tips will help you leverage your power and increase your chances of negotiating an advantageous provider contract.

Arm yourself with a charge master analysis A charge master analysis is a spreadsheet that records, tracks, and enables you to compare reimbursements in various ways—by payor,

procedure, timeliness of reimbursement, average reimbursement per payor or procedure, and so on. The format tells the financial story for your practice.

This gives you and the payor a clear picture of your reimbursement sources and both acceptable and unacceptable reimbursements for procedures. As bargaining material during the negotiation process, it's invaluable information and can be very convincing to a payor contractor. It is essential, however, that every figure can be documented and supported by evidence you can produce on demand.

Know what your competition is paid The big question in any negotiation is: what are other orthopaedic specialists in your area getting paid? Although costs for services vary from state to state and region to region, payors profit by negotiating contracts favorable to them, not YOU. Health plans will negotiate rates based on whatever the providers in a particular market will tolerate.

If you have an idea of what others are receiving (in aggregate by product line), you'll be better prepared to position yourself strategically when negotiating reimbursement rates. Gathering this information must be done carefully, to remain in compliance with local, state, and federal guidelines; using a consultant or specially designed software may be advisable.

Compare fee schedules Medicare allowables aren't always the basis for reimbursement. What do you do when your targeted health plan presents you with a proprietary fee schedule that has no consistent relationship with Medicare payment rates?

Your best response is to choose your top 40 current procedural terminology (CPT) codes—the top 20 by volume and the top 20 by total reimbursements—and ask the payor what reimbursements would be for those codes. This gives you a way to compare the plan's reimbursements with Medicare's allowables and your current reimbursements.

Assess your geographic leverage How close, geographically, are other orthopaedists or specialists in your field? If you are one of a few—or the only provider in your area—or you provide a service that others don't or isn't available in your area, you have a bargaining bonus during negotiations.

Is the network worth it? If the contracted in-network rate won't support your costs and the payor is unwilling to negotiate a better rate, consider staying out-of- network and billing the patient for the balance of the unpaid charges. But before you terminate your agreement, weigh the pros and cons by anticipating your losses.

How much revenue will you lose if these patients are required to seek orthopaedic services elsewhere? Will the out-of-network revenue offset these losses? Don't forget to factor in the displaced-patient dissatisfaction level.
If you serve a significant number of covered patients, proposing to end your contract and go out-of-network may make the payor reconsider, based on the considerable effort and expense involved in placing insured patients elsewhere, with a different provider. Now, the payor must weigh the cost and staff time it will take to re-assign those patients to other providers (if any) in your area, and balance this task against the potentially less costly and more convenient alternative of agreeing

to more favorable reimbursement on your renegotiated contract.

Balance billing is an option Most practices routinely require patients to agree to be responsible for balances left unpaid by the payor. If you need to recover your costs, you can bill the patient for the balance. Regardless of your collection success, this tactic will likely create some level of dissatisfaction among patients, who may make their indignation known to the health plan. Pressure from patients may even prompt plans to improve future reimbursements.

Limit your contract Accepting a blanket reimbursement rate for all coded services and procedures on the health plan's list can frequently result in significant and consistent losses on codes reimbursed at below cost. In some cases, it makes sense to carve those out of the contract entirely and limit your coverage list to procedures that are reasonably reimbursed.

If the plan won't agree to increase its payments for the carve-outs, or to offset lower reimbursements with proportionately higher payments for other procedures, it may be wisest to cut your losses by not renewing the contract.

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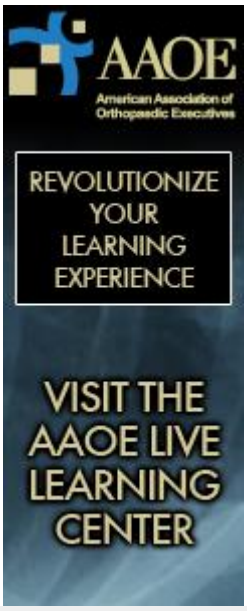

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