

# Negotiating a Contract With a Health Plan

You'll manage the process confidently if you ask these questions before it starts.

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**N**egotiating a contract with a health plan is often time-consuming and labor intensive, and it usually leaves family physicians feeling frustrated and uninformed. This should come as no surprise. After all, the contracting process is structured to put the physician at a distinct disadvantage. The health plan typically enjoys the luxury of a dedicated legal department, advanced software systems, and a staff of financial and network analysts paid to gather and organize information regarding benefit plan costs, competitive reimbursement levels and advantageous contract provisions that will guarantee the health plan's success in each contract negotiation.

As a result, family physicians and their staffs must be willing to invest significant time and effort in trying to ensure a successful negotiation and secure a mutually favorable contract. The recommendations in this article, while not exhaustive, are intended to arm you with tools and techniques to employ in the health plan negotiation process.

## Information is power

Before investing too much time reviewing contract language and legal clauses, you'll need to gather as much



information as possible about the health plan and its strategic plan for your community. This information will help you determine if your practice is operationally, financially and ethically compatible with the health plan. Review the information on the health plan's Web site to ascertain its mission, vision and values. Health plan Web sites often contain other important information, including the health plan's financial performance and past HEDIS (Health Plan Employer Data and Information Set; <http://www.ncqa.org/programs/hedis>) data.

If the Web site includes a provider search, identify the scope of contracting providers in your community and the percentage of community family physicians who have already elected to contract with the health plan. Identify the contracting hospitals and surgery centers in your community to ensure your hospital privileges and facility preferences will be acceptable. If possible, contact a family physician in your area and ask about his or her experiences with the health plan. For example, you might want to ask if the health plan has appeared supportive of family physicians and has been responsive to questions or concerns. You could also ask your colleague if the health plan or its payers have processed claims and remitted payment within a reasonable time period (typically 30 to 45 days). ►

# The more information you gather about the health plan, the better equipped you'll be to decide if it's compatible with your practice.

In addition, ask the health plan to provide you with the number of covered lives in your community and a sample of its key employer groups in your region. This will help you establish the health plan's importance to your practice. You might also want to ask about its governance structure, paying attention to whether family physicians are members of the board of directors, credentialing committees, and utilization and quality committees.

Contract negotiations are structured to favor the health plan over the physician.

Despite the health plan's inherent advantage, there are ways physicians can make the playing field more level.

It's critical that physicians arm themselves with as much information as possible about the health plan before beginning negotiations.

## Identify your leverage

Before entering negotiations with a health plan, identify any leverage you can use in the contracting process. This task is easier said than done, and timing can play an important role.

If a health plan is in the early stages of developing a provider network in your area, your participation is more valuable because it can help the plan sell its product and increase its membership. As a result, the health plan might be more willing to offer additional concessions in reimbursement levels or contract language revisions to secure your commitment to the network. For example, this would be an ideal time to negotiate higher reimbursement levels for your high-volume services, or to negotiate policy or procedure changes that will decrease the administrative burden to your practice.

However, if the health plan already has an established provider network, then you'll

need to explore more creative avenues for leverage points:

- Does the health plan need additional family physicians in your geographic area?
- Is the health plan planning to bid on an employer group whose employees heavily utilize your practice for their primary care?
- Does your practice offer any unique services that will benefit the health plan and its members? For example, is your practice accredited by a clinical quality organization? Or do you have outcome or quality studies or medical management data from other risk contracts that can demonstrate additional value to the health plan?

## The contract

Although health plan contracts differ in the terminology used and the order and organization of the provisions, the information contained in the contract is relatively standard and can be grouped into five broad categories: definitions, the health plan's obligations, the physician's obligations, term and termination, and general provisions. Key discussion points for each category are identified below. Family physicians should assess the importance and priority of these issues and identify any deal breakers before the negotiations start. (See the "Top 10 Deal Breakers" on page 51 and the "Top 10 Plums to Go After" on page 52.)

**Definitions.** The definitions section of the health plan contract is easily overlooked, yet it often contains important, albeit subtle, language distinctions that provide the framework for the relationship between the family physician and the health plan. Review the definitions critically, and keep these questions in mind:

1. Is the definition of a "clean claim" reasonable? The definition should focus on submission of a standardized claim form with all fields completed and all information required for the adjudication of the claim. Execution of contracts that expand the "clean claim"

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definition to include utilization of appropriate health plan coding standards may result in increased claim denials or delayed payments.

2. Is the term “contracting payer” clearly defined? Which health plans, employer groups or third-party administrators will have access to your negotiated discounts? Will you have access to a contracting payer list to ensure only approved payers are using the negotiated discounts? How often is the list updated and made available to contracting providers?

These questions are particularly important if you’re contracting with a preferred provider organization (PPO). If the PPO can provide a complete list of contracting payers and has a mechanism to update you regarding changes to the list, it is less likely to enter into “silent PPO” arrangements. A silent PPO is an arrangement under which a health plan rents its provider network to other entities, usually without the physicians’ knowledge, and the physicians are bound to accept discounted payments from these additional entities because of their contract with the PPO.

3. Does the definition of an “emergency” or “emergency service” include the prudent layperson standard? This helps protect the family physician against retrospective payment denials by defining an emergency as a condition that a prudent layperson with an average knowledge of health and medicine would reasonably interpret to be an emergency requiring immediate medical treatment.

4. In addition to defining “covered services,” does the contract also define “health care services”? If so, review the use of these two terms carefully throughout the body of the contract to ensure you are required to accept the health plan discounts only for covered services rather than all health care services.

For example, if the contract defines “covered services” as those services covered under the applicable benefit plan and defines “health care services” more broadly as any services provided by a health care provider, you should take special care to review the language later in the contract relative to claims payment. If the contract asks you to accept the applicable fee schedule as payment in full for “health care services” rather than “covered services,” you will be required to write off the difference between your billed charge and the health plan’s allowed amount, even for those services that are not covered under the benefit plan.

5. Does the contract require advance written notification of policy changes? It should. It is reasonable to expect at least a 30-day advance written notification of policy changes. In addition, you should request a provision requiring the health plan to meet with you to attempt to negotiate a mutually acceptable alternative if you object to a proposed policy or procedure.

**Health plan’s obligations.** This section of the contract outlines the responsibilities of the health plan or its affiliated payers. When reviewing this section, consider the following:

1. Does the contract require the health plan’s network name and logo to appear on all member identification cards? This will enable you to identify when the negotiated discounts apply and to cross-reference the entities accessing the discounts against the health plan’s contracting payer/employer list.

2. Are the applicable fee schedules incorporated into the contract as attachments? You should have access to the health plan’s fee schedule for all services you provide. At a minimum, submit a list of the services you provide in your practice and ask for the fee schedule amounts for those services to be incorporated into the contract as an attachment. If the health plan is not willing to divulge the allowed amounts, ascertain their rationale for withholding this information and proceed with extreme caution.

In addition, you need to find out how

■ You’ll need a creative strategy for gaining leverage during the negotiations if the health plan has an established provider network.

■ As you begin to look at the contract details, don’t overlook the important language contained in its definitions section.

### TOP 10 DEAL BREAKERS

1. The health plan’s ability to amend the contract without your signature.
2. Restricted access to all applicable fee schedule information.
3. Ambiguous definition of the entities that can access the contract and discounts.
4. Inability to independently establish panel limits and practice parameters.
5. Any reference to a “most-favored-nation” clause.
6. Unacceptable risk levels or risk for services you cannot manage.
7. Cumbersome or nonstandard coding/billing requirements.
8. Application of the fee schedule for noncovered services.
9. Labor intensive referral or prior authorization requirements.
10. Timely filing requirements shorter than 90 days.

the health plan handles fee schedule changes. Contracts often will reference annual fee schedule updates, or updates due to changes in CPT or HCPCS codes. Ask about the health plan's policy regarding midyear fee schedule changes. Can it make overall fee schedule methodology changes throughout the contract year, or merely adjust allowed amounts on a code-specific basis? In addition, if the health plan maintains the ability to implement midyear adjustments to the fee schedule, you may want to consider requesting the ability to negotiate midyear changes from the physician perspective as well.

■ In the contract section outlining the health plan's obligations, push hard for access to its fee schedule for the services you provide.

■ You should consider a "most-favored-nation" clause to be a deal breaker.

You should also ask about the notification provisions relative to fee schedule changes, and determine whether they are acceptable. It's reasonable to expect the health plan to notify contracting providers in writing, and in advance, of changes to the fee schedule so physicians can assess the financial implications of the changes to their practices. Advance notice of at least 30 days is typically required, and if the fee schedule is an attachment to the contract, consider requesting signatures by both parties be required before implementing changes to the fee schedule attachment.

Finally, inquire as to how the health plan determines the appropriate fee for each service, and whether it is offering you a standard fee

schedule or is willing to negotiate an individual fee schedule for your practice.

3. Does the contract include a "most-favored-nation" clause that requires you to offer the health plan the lowest, or most favorable, rate you have negotiated with any provider network or payer? Your contracted rates with other health plans or payers are confidential and proprietary, and should not be applicable to any other negotiations. Consider requesting this language be removed from the contract in its entirety. Other suspicious language to remove from the contract includes provisions allowing the health plan to offer multiple discount arrangements or fee schedules for their clients. Each payer and employer group should be tied to one fee schedule.

4. Does the contract provide a prompt-payment provision? It is reasonable for you to expect your claims to be processed and paid within an acceptable period, usually within 30 days. If your state's insurance department has passed prompt-payment legislation, your contract should reflect that the health plan or its payers will comply with any applicable prompt-payment regulations. In addition, if your state's prompt-payment regulations include exclusions such as workers' compensation claims or self-funded employer claims, you may wish to discuss the addition of prompt-payment contract language for these claims as well.

5. Does the contract include a provision that requires the health plan to obtain your written consent to participate in any new benefit plans the health plan offers? Often contract language is drafted to require physicians to participate in all benefit plans offered by the health plan. The administrative burden and financial considerations vary from plan to plan, and family physicians should consider the merits of each benefit plan before participation.

6. Does the health plan offer electronic business solutions that can reduce your practice expenses and increase workflow efficiencies? For example, if the health plan requires referrals, does it offer electronic referral capabilities? With electronic referrals, your employees simply enter or amend referral information online, thereby avoiding the cumbersome process of completing paper referral forms and faxing them to all parties.

In addition to asking about electronic referrals, ask about electronic claims submission and assess your practice's ability to comply

## TOP 10 PLUMS TO GO AFTER

1. Access to complete fee schedule information at all times.
2. Interest payments for clean claims not paid within 30 days.
3. Multiyear contracts with predefined fee schedule escalators.
4. Ability to opt out of specific benefit plans.
5. Ability to negotiate individual fee schedules that apply only to your practice.
6. Financial incentive programs that reward sound medical management.
7. Reduced or minimized referral and prior authorization requirements.
8. Advance written notification of changes to policies and procedures.
9. Online access to eligibility, benefit and claim information.
10. Utilization of standardized credentialing/recredentialing applications.

## Identify any deal breakers before the negotiations start.

with this provision. Identify the health plan's payment and remittance advice process and whether it is carried out on paper or electronically. Finally, find out whether the health plan provides easy access to membership eligibility and benefit verification information. Is the information available online, or will your office staff have to verify the information through telephone access? If the telephone is required, what steps does the health plan take to ensure providers or their staff will not spend valuable time on hold waiting for a customer service representative?

7. Does the contract require the provider credentialing and recredentialing processes to be completed in a reasonable time? The health plan should be able to complete the credentialing process within a 90-day period assuming all required information is provided at the time of application. Extensively long credentialing periods may be problematic if patients are eager to schedule an appointment and you are not yet approved by the health plan.

If your practice utilizes a standardized credentialing application, review the contract language or policy manual to ensure the health plan will accept your credentialing application format. This tends to be a bigger concern for bigger groups, in which the number of physicians makes credentialing a bigger hassle.

**Physician's obligations.** When reviewing the provider's contractual obligations, keep the operational efficiency of your medical practice in mind, and assess whether the proposed obligations are consistent with community standards and your own internal procedures.

1. Does the health plan require that only contracting providers can provide evening and weekend call coverage? If so, will that work for your practice? In addition, review the health plan's policies relative to the utilization of physician assistants (PAs) and advanced registered nurse practitioners (ARNPs). If your practice employs these providers, make sure you understand the health plan's credentialing and recredentialing requirements, as well as its policies relative to billing for PA and ANRP services. Many health plans also implement

reduced fee schedules for physician extenders, so consider the financial implications to your practice as well.

2. What is the timely filing requirement? Is it reasonable for your practice? Although most physician practices file claims on a daily or weekly basis to improve cash flow, the health plan's timely filing requirement should be long enough to allow your practice to identify overlooked claims and submit them for payment. While some health plans will allow up to 12 months for timely filing, a minimum of six months is recommended.

3. Does the contract define 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 this language be added to ensure the coding and billing requirements across all of your contracts are consistent. Special or nonstandard billing or coding requirements increase the administrative burden on your office staff and often result in unintentional errors.

4. Most health plan contracts contain the provision that you may not discriminate based on age, race, sex, national origin, religion, medical condition or health status. However, some nondiscrimination clauses also restrict discrimination on the basis that a patient is a member of the health plan. In these cases, consider asking the health plan to add a statement to the contract giving you the ability to designate a maximum panel size or participation status (e.g., open to new patients, established patient only or closed to new patients) and stating that such designation does not constitute discrimination as prohibited by the contract. In addition, beware of language that requires your participation with the health plan to be consistent with your participation status with other payers. You should maintain the ability to independently manage your payer mix as you deem appropriate. This will prevent the health plan from making up a disproportionate percentage of your practice.

5. Are the health plan's requirements for access and retention of medical records

■ Make sure the contract requires the health plan to finish the provider credentialing process in a reasonable time.

■ While reviewing the physician's contractual obligations, consider how they'll affect your practice's efficiency.

■ You might want to push for language that allows your claims to be filed on generally accepted forms in accordance with standard coding and billing practices.

reasonable? Does the contract language restrict access of medical record information to the minimum necessary rather than the entire medical record? Limiting medical record access to the minimum necessary not only protects health information but also contributes to the efficiency of your practice as the provision of medical record copies can be costly.

**Term and termination.** Health plans often offer contracts with a multiyear initial term combined with a termination without cause provision that does not allow termination of the contract during the initial term. Essentially, this allows the health plan to lock in the physician for a multiyear term. If an extended initial term is unfavorable for your practice, you may want to request 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. Otherwise, consider negotiating for an accelerator clause that guarantees certain fee schedule increases each year of the initial multiyear term. For example, if you are willing to execute a multiyear agreement, ask the health plan to write into the contract an agreement to increase the fee schedule at a predetermined percentage each year, or to adjust the fee schedule for subsequent years in accordance with a published economic indicator such as the U.S. Consumer Price Index.

**General provisions.** The general provisions section of the contract provides a location for the health plan attorneys to address any miscellaneous legal issues. It warrants a detailed review. As a rule, physicians should review each provision in this section for reciprocity to ensure that the family physician is afforded the same legal rights and protection as the health plan. Beware of language that appears one-sided or does not include equal responsibility or benefit to both parties. Other issues to consider include the following:

1. Do contract amendments require signed execution by both parties? Often health plans attempt to limit their administrative burden by amending their provider agreements without the physician's prior written consent. You should be afforded the opportunity to carefully review all contractual amendments in advance, and signature by both parties for amendments is highly recommended.

2. Does the contract include equal and mutual indemnification language? If the con-

tract requires you as the physician to indemnify and hold the health plan harmless, you should make sure the contract also requires the health plan to afford you the same protection.

3. Does the contract make it clear that any arbitration hearings will take place in the physician's community rather than the location of the health plan's corporate office? In addition, identify any physician-appeal processes that must be exhausted before initiating arbitration and any applicable time frames for filing appeals and arbitration requests. Review the language to ascertain which party will be responsible for the cost of arbitration, or if the parties are required to share the cost equally. Is the arbitration binding? Does the arbitrator have the authority to award punitive or other damages? Although issues between physicians and payers rarely make it to arbitration, you should be familiar with the requirements of the arbitration provisions and make sure you are willing to comply with the terms.

4. Does the contract restrict or limit the physicians' ability to pursue or participate in class-action lawsuits? The recent proliferation of class-action lawsuits against health insurance companies has prompted many health plans to attempt to restrict their contracting providers from future participation in similar legal proceedings. It is recommended that this type of restriction be removed from the contract.

## Financial assessment

A thorough review of the health plan's reimbursement mechanisms can be a daunting task. Although an assessment of the health plan's fee schedule might be straightforward, the addition of capitation and other forms of shared risk and financial incentives can significantly complicate the analysis. If this is the case, here are some questions you should consider asking:

- If primary care capitation is involved, will the health plan give you detailed information about which specific services are covered under the capitation? The plan should be able to do this, which will help you determine whether the capitation is reasonable.

- Are the capitation rates age and sex adjusted?
- Does the health plan have a process in place to severity adjust the capitation rates, which will provide a higher capitation rate for those members who have chronic or co-morbid conditions that typically result in a higher

■ You need to decide whether it would be a problem for your practice if you were locked into a contract with a multiyear initial term.

■ The contract's general provisions section should be reviewed in detail to make sure each provision offers reciprocity.

■ Language limiting your ability to participate in class-action lawsuits should be removed from the contract.

total claims expense? If the capitation is not severity adjusted, ask about the health plan's stop-loss provisions, which may help limit your risk to a prespecified dollar amount per member for the contract year.

- If benefit plans and co-payment levels change, how will this affect the capitation rates?
- Does the health plan implement employer-specific capitation rates?

- Will the health plan allow fee-for-service payments rather than primary care capitation until a predefined member threshold is met? This flexibility can be beneficial to the primary care physician while establishing a membership panel. If your panel size is small (e.g., fewer than 50 members), the total monthly capitation payment can be quickly depleted and leave your practice with a loss for the month.

- Does the contract include risk for nonprimary care services? How much control do you have over these services? Are any services carved out of the risk? Risk contracts often exclude certain categories of services for which the family physician cannot easily manage care, such as behavioral health services, self-referral services or emergency services provided out of the health plan's service area. Before entering into a risk contract, assess your ability to manage the scope of services included in the risk arrangement, and negotiate the exclusion of services beyond your control.

- Is an audit process in place to ensure only authorized services were paid? Contracts with high levels of risk are difficult to assess initially and often require high member counts to reasonably sustain the risk level. Therefore, they should be tracked carefully and entered into with extreme caution.

- Does the contract include other incentives for quality, cost-effective care or medical management? How are those programs developed and monitored, and how often will the family physician receive an update on the status? In addition, ask about physician input into the development of the incentive programs, review the criteria for the programs carefully to determine if the goals are attainable and find out whether the health plan makes staff available to assist the physician with data analysis and interpretation.

More information is always better, so don't hesitate to ask as many questions as necessary to fully understand the reimbursement arrangements.

## Policy manual review

Because most health plan contracts require physicians to comply with the health plan's policies and procedures, it is vital that the family physician review the policy manual before executing the agreement. The policy manual contains the details of the relationship between the physician and the health plan, and is often much more informative than the contract itself. The policy manual may include specific information regarding the health plan's credentialing requirements, claim submission and coding policies, appeal and grievance procedures, referral and prior authorization requirements, and quality and utilization management programs. This information will help you and your practice administrator determine the administrative burden on your practice, and it will help identify any staffing issues you might run into while trying to comply with the health plan's expectations. You should share the policy manual with your practice's administrative staff for their review and input.

## Good luck

Ultimately, family physicians need to realistically assess their importance to the health plan, and use any advantage available in the negotiation process. Keep in mind that your best leverage might be your willingness to walk away without a contract. **FPM**

Send comments to [fpmedit@aafp.org](mailto:fpmedit@aafp.org).

■ The addition of capitation makes your review of the health plan's reimbursement mechanisms a daunting task.

■ Both you and your administrative staff members should review the health plan's policy manual before executing the agreement.

■ Always remember that your best leverage might be your willingness to simply walk away from the contract negotiations.

## CLARITY IN CONTRACTING

Earlier this year, Colorado nearly became the first state to implement a standard managed care contract and thereby require transparency in contracts between physicians and health plans. A veto by Gov. Bill Owens (R) stopped S.B. 198, which would have required health plans to disclose all the terms of their contracts, from becoming state law. For more on the vetoed bill, see *AAFP News Now's* post-veto article at <http://www.aafp.org/news-now/government-medicine/20060531contractsbillveto.html>.

Along those same lines, the AMA offers a Model Managed Care Contract that can help you familiarize yourself with the structure and language of a fair contract. A free copy is available at <http://www.ama-assn.org/ama/pub/category/9559.html>.