Frequently Asked Questions about Contracts with Third-Party Payers

1. **What is the difference between being categorized as a "medical practice" or an "ancillary practice"? How important is this designation?**

   The category designation that your clinic receives will be based on the services your clinic provides, the number and types of providers, and other information regarding your clinic operations. Be prepared to share information about your operations with the insurance companies (e.g. number of sites, types of providers, services offered, etc.). The designation may also be dependent on whether or not your clinic can be considered a patient-centered medical home, essential community provider, or if your providers have hospital privileges. While the third-party payer makes the designation, it is important for your clinic to be aware of how you are being categorized so that you can ensure that your clinic is classified appropriately and that you are aware of the requirements of that designation.

2. **What terms are negotiable beyond the fee schedule? What are some terms in the contract that we can negotiate that would make our work easier?**

   There are several topics you can discuss with the third-party payer that may be helpful to you. Here are some recommended topics to discuss:

   - While Medicare and Medicaid reimbursement rates are not negotiable, you may negotiate reimbursement rates with private third-party payers, including Medicaid Managed Care.
   - It is possible to negotiate services beyond your designated service type. For example, if your STD clinic provides integrated services (i.e. STD and family planning), you may negotiate to provide services outside of the typical family planning services, such as prenatal services, if your clinical staff is qualified to provide those services.
   - You may be able to negotiate increased rates/premiums for after-hours, Saturday, or telemedicine services.
   - Many contracts auto-renew, year after year. You may negotiate the addition of a 30 day cancellation clause. This provides some protection if you are not satisfied with the contractual arrangement at any time once the contract is executed.
   - Negotiate reimbursement rates for lab betrig.com services you can perform in-house, if you have capacity to provide them.
   - Negotiate to expand the claim submission (timely filing) timeframe. Many third-party payers offer 60 or 90 days from date of service. Ideally, 180 days is helpful given the "churning" [1] that is currently occurring with clients' third-party payer coverage.
   - Assure there is a mutual "hold harmless" indemnification and dispute resolution language.

[1] Churning is defined as transition from one type of health insurance coverage to another or from having health insurance coverage to not having coverage or vice versa. http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf

- There may be a rate review/change request process that is contractual. Ask if it can be, or how and when rate changes will be negotiated and/or communicated. If it is not in the contract language, and/or the third-party payer doesn't want to add it, assure the process for requesting changes is clearly outlined.
- For services that your clinic would like to add in the future, find out what the process is for having the services added post-contract. (For example, if your clinic wants to add a new test/treatment six months post contract execution, how would you add it?)
- "Clean" claim payment terms assure that there is language guaranteeing your payment in a timely fashion once a clean claim has been submitted. Most third-party payers have language to this regard, and 30-45 days or less is reasonable.
- If possible, it is recommended that you have an attorney with experience reviewing health care contracts review the contract before it is executed.

3. What are some questions we should ask/points we should clarify with the third-party payer that are not contractual that will make contract execution easier?

- As mentioned above, if the rate re-negotiation process or service addition protocols are not contractual, assure that you understand how to get these tasks accomplished.
- Meet your claims manager, and have this person's phone number and email. Having established initial contact is helpful in solving problems that will occur in the future.
- Assure you have a good understanding of the denials process, including claim resubmission. Ask who you can contact to get answers to questions about denied claims, or when new/different "edits" are implemented[3].
- Understand clearly what data the third-party payer will request from your clinic. For example, they may request data for various HEDIS[2] measures. Ask whether they will be able to gather the information themselves or if your clinic will need you to generate the report. Ask if the insurance company is expecting your clinic to meet any specific goals/benchmarks. For example, they may want you to meet a screening goal for the percent of your clinic's female patients under 25 years old being screened for chlamydia.
- Understand and ask about the entire contracting and credentialing process. Ask about the length of time it will take and information that the insurance company needs from the clinic and when. Ask about credentialing of providers, and if the credentialing is internal vs. external and steps/timing involved in this process.

[2] The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. http://www.ncqa.org/HEDISQualityMeasurement.aspx

[3] Edits are changes or new "rules" that the third-party payer implements from time to time. These edits are typically focused on changes they are implementing to procedure codes that limit reimbursement for various treatments/visits.

4. **We have a fee schedule that doesn't match up with the fees the insurance company is offering. Is this important to consider and if so, are there suggestions on how to handle this?**

   It is important to establish a rate structure that allows you to receive the full contracted rates from all contracted third-party payers. The insurance company will pay your clinic what your clinic charges them **up to** the contracted rate. For example, if you contracted with the third-party payer for a specific service at $100, and you have the charge established in your system at $85, and generate a bill to the third-party payer for $85, they will pay you $85, not $100. If the charge is set up in your system as $115, and you charge them $115, they will pay you $100. Setting your clinic's charges *at least as high* as your highest contracted reimbursement rate, and assuring that you are accounting for expected revenue, (not charged revenue) is one practical way to adjust this issue.

   It is, however, important to be aware of your competitors' rates for the various services in your geographic market. While many non-profits are pricing their services lower than the competition, it is still a good idea to be aware of service and market pricing. Because many non-profits have lower charges, they typically find that they need to increase fees for services as they start to contract with third-party payers. However, setting the rates too high may create a barrier for self-pay fee payers. One way to both capture full insurance reimbursement, yet not make fees unreasonably high for the fee-for-service payers is to adjust the sliding fee scale, *if you use one*, to accommodate for increased rates, and still keep your fees affordable for self-pay clients.

5. **We know what our costs are and the reimbursement the third-party payers are offering is too low. What can we do?**

   While there can be some negotiation of rates, it is important to know that your cost to deliver the service is typically not the concern of the third-party payer, and telling them your cost/asking to be reimbursed for your costs is most likely not an effective negotiating point. A better strategy is to focus on implementing operational changes to reduce the cost of services (scheduling and/or staffing strategies, etc.) to bring the costs into alignment with rates being offered. Remember, third-party payers have already established a network that has accepted their rates, so they are unlikely to negotiate anything significantly higher.

   Another strategy is to talk with your peers, and find out the reimbursement ranges for the services your clinic provides prior to beginning negotiations with a third-party payer. Once you have successfully negotiated with one third-party payer, it is effective to compare those rates with a potential new third-party payer, and use the existing contracted rates as leverage (if the rates are higher than what you are being offered).

6. **What if my clinic doesn't have the staff or software needed to process third-party payer claims?**

   There are several options that can ease the transition into billing third-party payers. The first, and often the recommended option, for a clinic new to billing (without billing staff) is to contract billing services to an outside entity – a third-party billing company. The cost of these services is typically a percentage of revenues collected; a methodology that protects your clinic against paying the billing entity for denied claims. While the clinic still has the responsibility of assuring data is gathered accurately, the fiscal and IT functions are minimal. Most billing companies will generate reports that provide all information needed for accounting purposes.

   Another option which allows your clinic to begin limited billing with a minimum upfront investment is to process Medicaid claims via a state portal system. Some third-party payers may have this option as well. This strategy may work for the short-term while your clinic is learning billing but is not a preferred long-term solution as it does not allow your clinic to manage its accounts receivable. Sending paper claims is also sometimes an option for clinics new to billing, but some third-party payers may not accept paper claims now, or in the near future.

7. **In previous years we have tried to contract with private third-party payers, but they were not interested. What information (data) do we need to engage them?**

   Being well prepared for your initial contact is helpful. Some of the items to consider are listed below.

   - Be able to clearly and concisely articulate the types of services, number of clients (both total and those with their specific insurance), number/type of providers/sites and hours of operation, and your capabilities/plans to process claims. Any data you can share about patient demographics, HEDIS measures, as well as sharing any knowledge you may have gained about their network needs. Share any accreditations/credentialing information (licensing, Medicare/Medicaid certification, etc.) you may have.
   - Gather any information you can from colleagues who have gone through the process. Ask them what was helpful to ask or information to have for the first meeting.
   - If you are an Essential Community Provider (ECP) share that information. Issuers that offer plans on the Health Insurance Marketplaces now have a requirement under the Affordable Care Act to include a sufficient number and geographic distribution of providers serving low-income, medically underserved individuals (i.e. ECPs).
   - Leverage any existing relationships you have (with other third-party payers, partnerships with other community providers/primary care sites, any type of network you may be a part of, etc.).
   - If you can gather any information on what their needs may be, utilize that information. Examples include: the third-party payer may have a geographic need (limited providers in your clinic's geography), or a performance need (their performance is less than average on certain HEDIS benchmarks where you perform well), or a need to have ECPs in their network.

- If the insurance company happens to be your personal third-party payer, that can open the door – they will be more inclined to speak with you if you are one of their customers.
- The easiest entity to begin billing with is often Medicaid, followed by Medicaid Managed Care. Consider starting here as your first step.

8. Is there a rule of thumb about how many patients we need to serve to be interesting to a third-party payer?

There is no specific number of patients you need to serve, but it is important to know how many patients in your clinic are served by a particular insurance company. If you don't know how many of your patients have insurance or a specific insurance, you can use the Sample Payer Mix Survey to find out.

9. We are a health department and we are paid less than the Community Health Centers (CHCs) for the same services from Medicaid and other third-party payers. Why is that? What can we do about it?

Sites that are designated as Community Health Centers (CHCs) provide a full array of services and meet stringent requirements to qualify for the enhanced reimbursement. A CHC is one type of Federally Qualified Health Center (FQHC) that receives grants under Section 330 of the Public Health Service Act and qualify for enhanced reimbursement from Medicaid and Medicare. To become an FQHC they must serve an underserved area or population, offer a sliding-fee scale for charges and provide comprehensive services, among others. FQHC requirements can be found at cms.gov or hrsa.gov if you would be interested in pursuing these grants and benefits.

10. Are there any reasons why third-party payers may be reluctant to contract with health departments?

Third-party payers may be reluctant to contract with health department clinics because they do not understand their mission or who the health department's patient population is. Listed below are a number of possible reasons:

- Third-party payers may assume their clients don't come to your facility.
- They may assume your clinic is grant-funded to provide services and do not realize that you charge for services.
- They may not be knowledgeable about the types of services that your clinic provides.
- They may not know how you can help them meet their HEDIS measures goals.
  They may have concerns that your clinic doesn't have the knowledge of how to manage claims processing or exchange information with them electronically. Remember, if your clinic doesn't have electronic claims, you may be able to hire an outside biller to process the claims electronically.

Be prepared to address these concerns at the beginning of your talks with a third-party payer. It is also helpful to ask them directly if they have any other concerns.

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