Guide to Payer Enrollment Success for Provider Organizations

Better understand the payer world to overcome denials during provider enrollment

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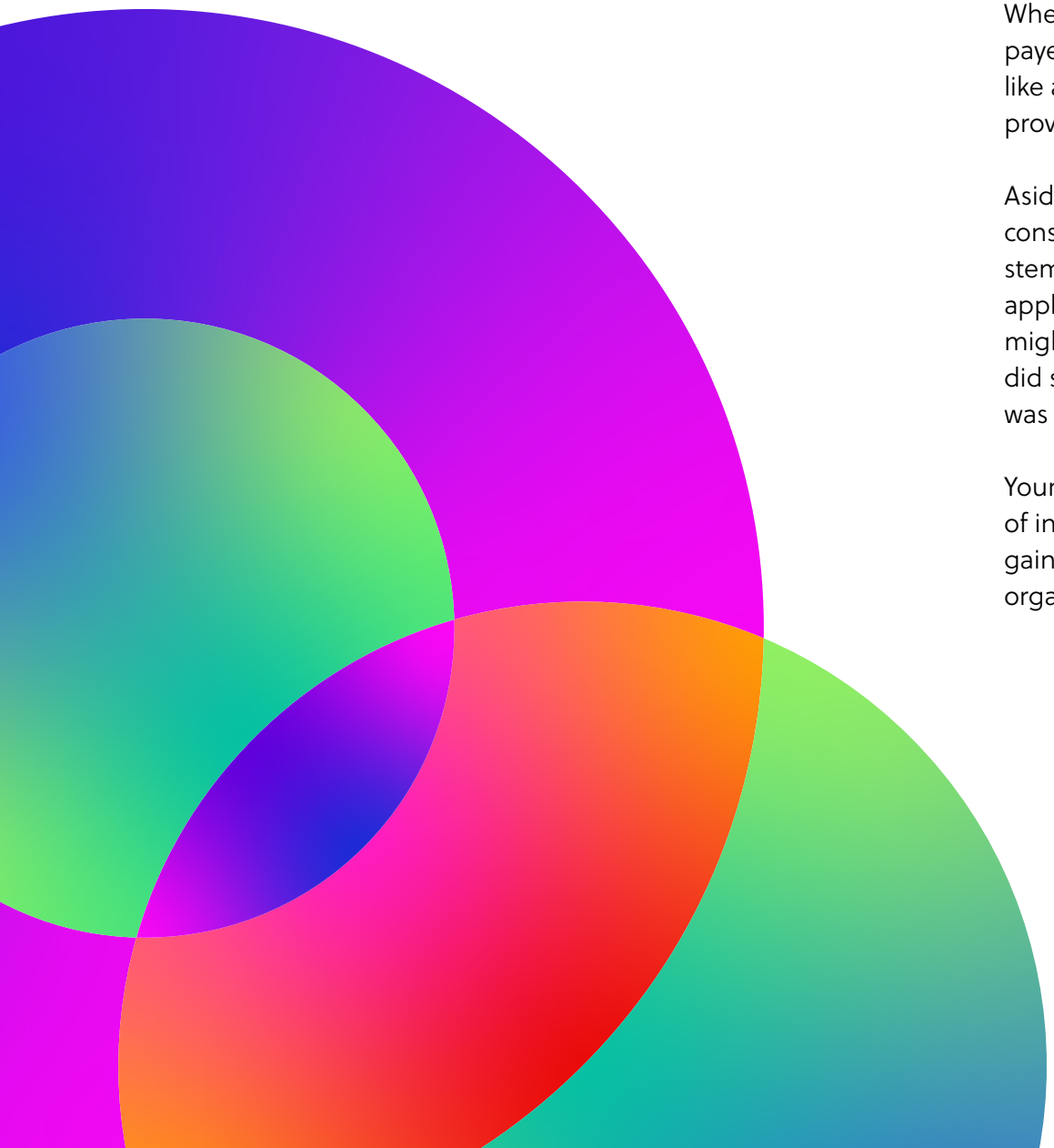
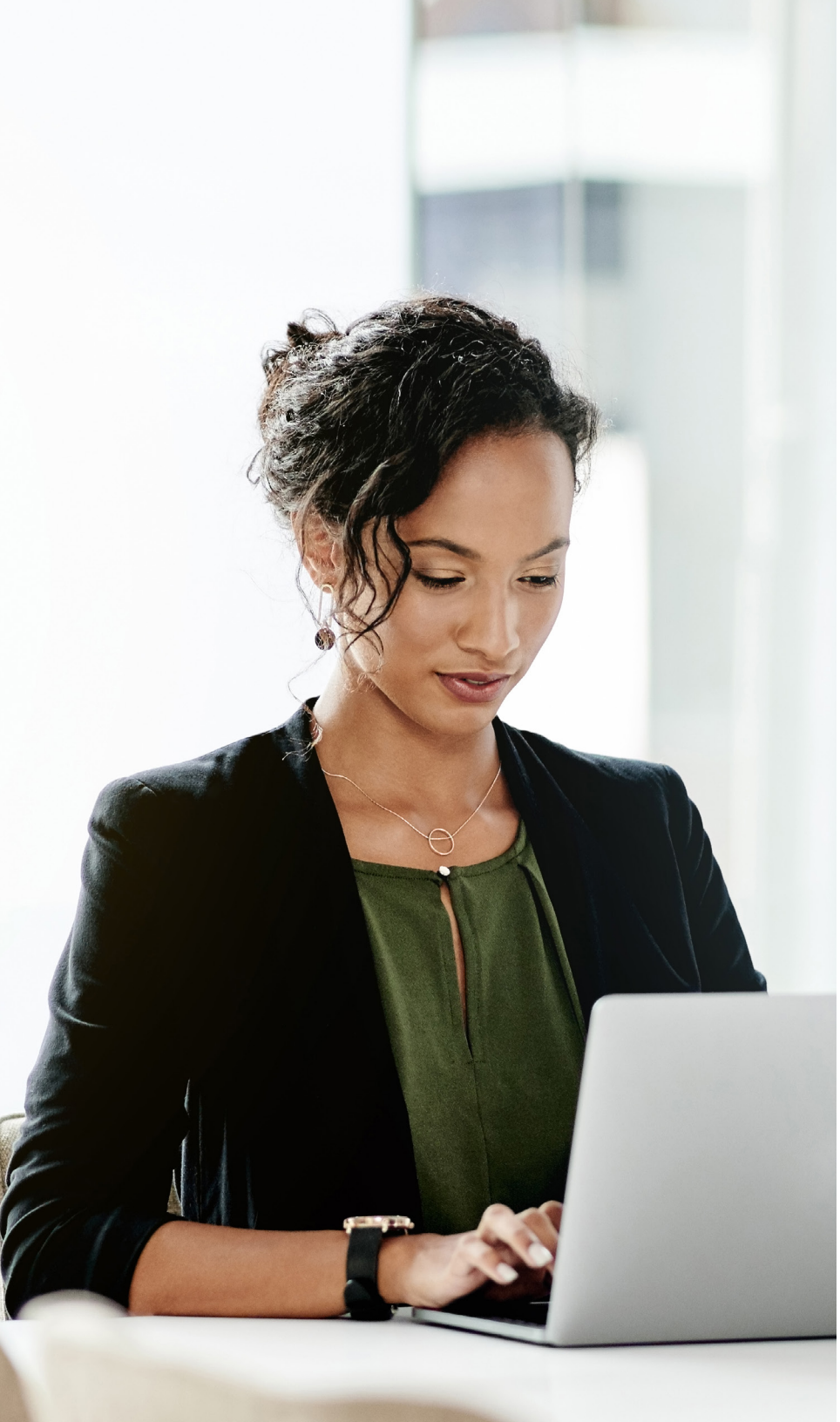


When enrolling your providers in Medicare, Medicaid, and private payers, much is out of your control. In fact, at times you might feel like an opponent rather than a team member in the effort to help provide adequate and competent care for patients.

Aside from enduring lengthy application processing times and constantly contacting payers for status checks, frustration can also stem from hearing the notorious "no thank you" from payers when applying for network participation on behalf of providers. You might be left wondering why a denial occurred—and if perhaps you did something wrong in your process or whether another factor was the cause.

Your sphere of control, or lack thereof, is one thing, but your sphere of influence is quite another. Here are ways to exert influence and gain some ground in the daily give and take between healthcare organizations and payers.



Understand what's happening on "the other side of the fence"

Like in hospitals, change rapidly occurs at payer organizations. Recent headlines reflect the healthcare insurance industry's issues, missteps, and pressures.

Gain a better understanding of the payer world to help your provider organization navigate the enrollment process and apply armed with that knowledge.

The following challenges abound in the healthcare insurance industry—and many closely align with the hurdles health systems face today:

- Administrative staff shortages, especially at customer-service level
- More claims to process, more offerings = increased administrative load, low morale, social backlash
- Knowledge and technology gaps:
  - Credentialing and enrollment professionals at all types of healthcare organizations cite inadequate training and technology resources for expanding job responsibilities and work volume
- Data access hurdles, including a disconnect between hospitals and payers regarding data exchange, and data are siloed in many systems within each organization
- Offshore staffing and insurance call center staffing issues
- New cost-of-care scenarios that require payers to continually review their operational policies and procedures

There are industry changes afoot as well, with direct effects on payer and provider organizations:

- Mergers and acquisitions (M&As)
- Healthcare payment reform (value-based care)
- A shift to patient-centered (customer-centric) service
- Provider shortages and burnout affect payers and provider organizations

Fortunately, the Council for Affordable Quality Healthcare (CAQH) is leading the charge when it comes to change for the payer industry. CAQH continues to update practitioner requirements to meet payer industry demands, and the organization strives to bring stakeholders together to help streamline the exchange of administrative and clinical healthcare data with the payer community.

Payers in the News

'In tears before I even logged in': Cigna call center workers challenge working conditions

The Guardian

Many Patients Billed for Preventive Care That Should Be Free: Study

US News

One Medical Employees Say Concierge Care Provider Is Putting Profits Over Patients

NPR

Backlash forces UnitedHealthcare to delay policy that would deny ER visit coverage

WINK News

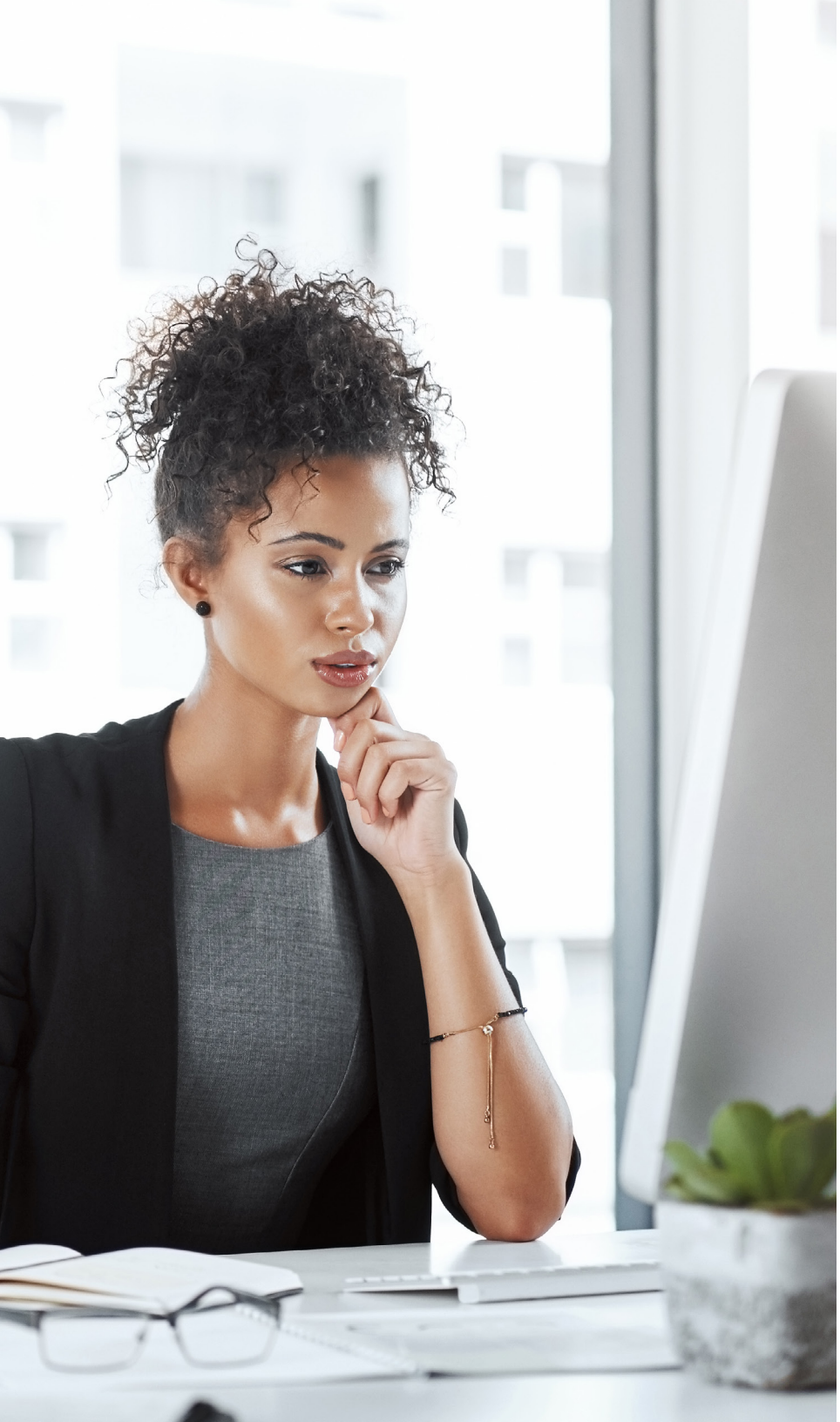
Why denials happen

Payers have the ability to set and adjust the number of providers allowed into their networks and to determine their qualifications. They institute limits while walking a fine line to save costs yet ensure their ability to deliver healthcare benefits promised to enrollees. Thus, a provider's application to an insurance panel can be denied for various reasons, application-error related or otherwise.

In addition, a payer may not necessarily deny a provider, but there could be geographic areas subject to competitive bidding limitations on reimbursement of certain services or products—or there may be a moratorium on a certain provider type, or in a specific geographic region.

Other common reasons for denials

- Failure to meet certain criteria or provider standards set by the payer
- Being out compliance with requirements of a payer's conditions of participation
- Oversaturation of a provider type in a community or service area
- Restrictions on or failure to meet additional requirements for out-of-state enrollments



Where you affect the revenue cycle

All subsequent reimbursements flow from enrollment, so a denial is seen at the organizational level as a loss of potential revenue. If there's ever a place to exert extra effort, it's at the application stage. Proper application completion and follow-up include:

- Primary source verification done well
- Applying an "investigator" skill set
- Persistence
- Consistence
- Documentation, Documentation, Documentation

Ways to highlight a provider's value

When a denial occurs, the goal is to submit additional information to get past the payer's "no," with an appeal, to clarify what unique or special patient community your provider services, and to request a conference call or face-to-face meeting with a decisionmaker to verbally and effectively convey your message.

Tip: Persistence counts, and in certain instances you can get beyond barriers using creativity. For example, try searching LinkedIn under the payer's company name to see employee titles and to uncover any common connections to create an introduction.

When a payer denies, it might be for lack of information, for example. They may look quickly at the provider type and base their decision on that, stating that the network is "closed." Do your research and spend the time on the cases that have the biggest financial impact.

Payers want to know, "What's the benefit?" What need or solution would the provider fulfill?

Know the answers and highlight the value your provider can bring to the payer to incent an agreement. Does your provider help a payer meet population health goals? Or, for example, if your provider treats patients in-home rather than in-facility, cite quantifiable cost savings, which could flip a decision.

Communicate to payers about the patient population the provider serves—especially when any of the following are included:

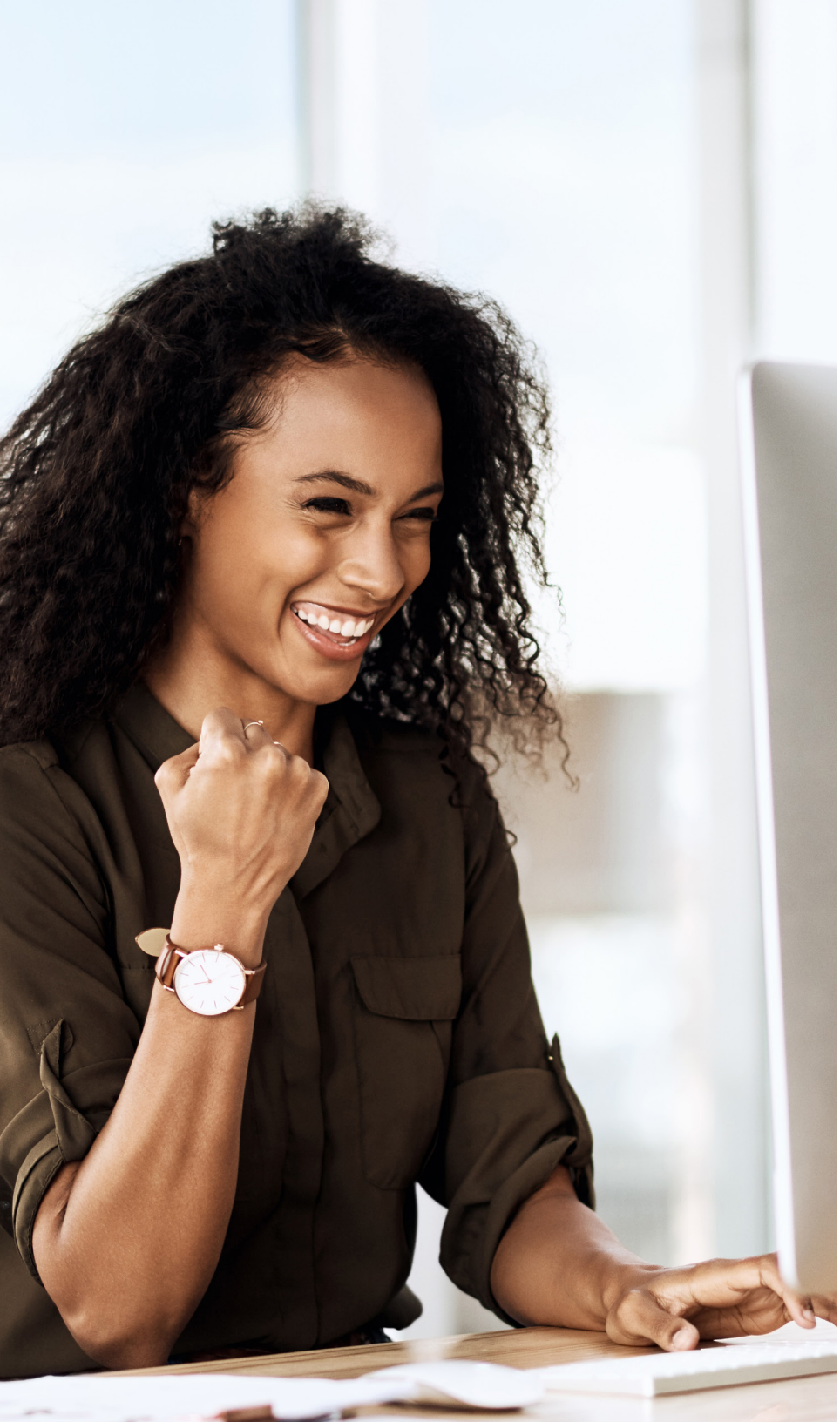
- Rural
- Indian Health Services
- Pediatric
- Geriatric
- Disabled
- Chronic condition
- Any non-English-speaking population

How to submit additional key data

Get creative with your approach to help open closed network doors. For example:

- Request a conference call face-to-face with a decisionmaker to verbally and effectively convey your message
- Request an appeal to clarify unique or special circumstances or services
- Get supportive letters from the provider community (referral partners of the denied provider)
- Be open to negotiating lower, competitive rates in exchange for volume, after getting your provider and stakeholder buy-in
- Suggest a trial period to serve a select number of patients and offer a free comparison analysis after the period ends (again, discuss with provider/stakeholder beforehand)
- Ask for a second level appeal from a decisionmaker or manager at the payer (check email signatures to determine rank)
- Appeal by phone rather than email or letter (unless the payer requests a formal written appeal)
- Request a conference call or ask for an in-person meeting
- Offer an in-service overview conducted by the provider to better understand their services
- Send a letter of interest that sells a payer on your provider to beef up the application

Last but not least, remember to take effusive notes and document everything.



Share your wins

Getting one in the win column when the provider was initially denied is a big deal and an opportunity to showcase your tenacity. If you're a manager, incent and reward wins. Document and share exactly how you did it for future reference—and communicate it to team members or consider making the action(s) that made the difference a part of regular protocol.

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