



2025 AHLA Annual Meeting

# Practical Considerations for Providers in Negotiating Network Contracts

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1

## Topics for Discussion



- Negotiating strategies and tactics (“Top 10” List)
- Why good rates are often not enough (e.g. recoupments, downgrading, payment policies, site of service, etc.)
- Value-based payment components to network participation – What’s new and how to tackle what’s old and no longer working
- Challenging the adequacy of payer networks and why such challenges matter when negotiating with payers
- Direct messaging to purchasers (i.e., members and employers) – enlisting assistance from patients and health plan sponsors while steering clear of tortious interference
- Questions and answers

2

# Negotiating Strategies and Tactics



3

## 5 Key Considerations – from an attorney who negotiates contract terms with health plans

1. Alternatives to network participation
  - OON – higher rates v. lower volume (higher patient cost share) and less dependable processing/payment of claims
  - Repricing and other single case agreements
  - No Surprises Act IDR
2. Address payer offset rights proactively
  - No offsets absent agreement on overpayment
  - No offsets pending resolution of provider objection to unilateral overpayment finding by plan

4

## 5 Key Considerations – from an attorney who negotiates contract terms with health plans (cont'd)

3. Take advantage of state prompt payment laws
  - Incorporate state law into Agreement so to provide basis for seeking damages for violation, even if there's no private right of action
  - Extend prompt payment protections to self-funded plans
4. Ensure that Agreement does not change to your detriment
  - Default requirement that all amendments must be bilateral and in writing
  - Limit plan's unilateral right to amend Agreement to conform to changes in the law (only as needed and only with respect to new laws)
5. Plan for potential expansion of providers covered by Agreement
  - Limit time period in which plan can choose what rates to pay already-participating provider added to Agreement

## 5 Key Considerations – Business perspective

1. Document value proposition
  - List the value in the areas of access, quality, and affordability
  - Understand timing and urgency
2. Conduct data and analytics study
  - How do rates compare across payers and the competitors
  - Analyze contract performance versus expectations
3. Define payer reliance and risk
  - Importance of payer participation as it relates to overall strategy and objectives
  - Impact on payer if provider is out of network

## 5 Key Considerations – Business perspective



4. Summarize current state (existing contract)
  - Identify the prevailing issues
  - Review key contract provisions
  - Timing on when the last negotiation occurred
5. Evaluate current relationship
  - How to characterize as it relates to other payers
  - Frequency of communications
  - Relationship of payer and the competitors

## Negotiating strategies and tactics (“Top 10” list)



1. Consider alternatives to network participation
2. Address payer offset rights proactively
3. Take advantage of state prompt payment provisions
4. Consider all of the ways in which the Agreement might change
5. Plan for potential expansion
6. Document value proposition
7. Conduct data and analytics study
8. Define payer reliance and risks
9. Summarize current state
10. Evaluate current relationship

# Why Good Rates Are Often Not Good Enough

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9

## Why good rates are often not enough

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### Overview

- 2 sources of healthy rates and collections
  - Expected rates – align with market and provider expectations
  - Actual rates – what is actual collected on the expected rate (“yield”)
- Actual rates are impacted by such elements as prior authorization, downgrading, payment policies, appeals, etc.

10

## Why good rates are often not enough



### Expected Rate

- Conduct an internal analysis and assessment
  - By payer
  - By product
  - By service
- Involve leaders throughout the organization (discharge planning, care coordinators, pharmacy, etc.)
- Identify peer providers to compare your internal analysis
- Develop an approach to close any gaps

## Why good rates are often not enough



### Actual Rate (Yield on Expected Rate)

- Measure, measure, measure...
- Determine root causes (prioritize by financial impact, ease of implementation, timing, etc.)
- Common areas affecting the yield
  - Prior authorization
  - Appeals and reconsiderations
  - Claim adjustments (overpayments, timelines)
  - Clinical downgrades due to medical record request
  - Billing and payment policies
  - Site of service

## Why good rates are often not enough



### Actual Rate (Yield on Expected Rate) - continued

- Approaches/solutions to enhance payer contract performance
  - Establish Joint Operating Committee
  - Propose amendments to clarify/rectify ambiguous provisions
  - Consider involving regulatory agencies as needed
  - Develop and share payer performance scorecards
  - Initiate and follow pre-arbitration processes to resolve disputes
  - Communicate with key stakeholders
  - Take legal action as needed

## Value based Payment Components to Network Participation



## Value based payment components – new v. old



### Overview

- Overall reimbursement is still predominately based on a fee-for-service chassis
- Value based reimbursement can take many forms and can serve as a supplemental revenue stream

## Value based payment components – new v. old



### Evaluation phase – Go v. No-Go

- Risk tolerance – none, upside only, etc.
- Investment requirements – labor, data systems, etc.
- Network composition and control – controls over clinical quality, case management and care coordination
- Market factors – competitors, payer alignment, # of attributable members, products, current experience



## Value based payment components – new v. old



### Key components

- Some value-based contracts introduce a risk/reward component
- The majority of all value-based contracts include quality measurements; some include quality and cost of care measurements
- Quality measurements
  - Align with industry standards (HEDIS, NCQA, CMS Stars)
  - Limited number of measures
  - Consistency across payers

## Value based payment components – new v. old



### Key components - continued

- Cost of Care elements
  - # of attributed members
  - Revenues
  - Expenses
  - Network composition
  - Care management fees
  - Stop-loss
  - Mid-year performance reports and advances

# Challenging the Adequacy of Payer Networks



19

## Challenging the adequacy of payer networks



### Overview

- Leverage provider's reputation in/share of relevant market
  - Plan members want the provider to be in-network
  - Even more important, plan sponsors (*i.e.*, the members' employers, in the case of larger companies that self-fund their insurance coverage) want the provider to be in-network
- Leverage potential arguments that without provider, administrator will not meet network adequacy requirements
  - Medicare Advantage
  - Medicaid MCOs (Pennsylvania as test case)
  - Commercial (BCBSIL/Springfield Clinic test case)

20

## Medicare Advantage – Network Adequacy



- Federal guidance at 42 C.F.R. § 422.116 -- mandatory access standards expressed in terms of beneficiary time (minutes) and distance (mileage) from network providers
  - Standards take into account type of provider and type of county
  - Example – PCPs available at a maximum of 10 minutes and 5 miles from beneficiaries in a “large metro area”
- Required standards – example:
  - 85% of beneficiaries in micro or rural county must have access to at least one provider/facility of designated specialty types within the published time/distance standards
  - 90% of beneficiaries in large metro areas must have access to at least one provider/facility of designated specialty types within the published time/distance standards

## Medicaid MCO – Network Adequacy (Pennsylvania)



- “Except as otherwise authorized in this section, a plan shall provide for at least 90% of its enrollees in each county in its service areas, access to covered services that are within 20 miles or 30 minutes travel from an enrollee’s residence or work in a county designated as a metropolitan statistical area (MSA) by the Federal Census Bureau, and within 45 miles or 60 minutes travel from an enrollee’s residence or work in any other county.” 28 Pa. Code § 9.679(d) (emphasis added).
- If a Medicaid MCO is unable to meet the above standard, it must provide the single state Medicaid agency with “a written description of why it is unable to do so and its alternative arrangements to ensure access to health care providers of these services.” 28 Pa. Code § 9.679(f).

## Commercial – Network Adequacy (Illinois)



- Illinois' Network Adequacy and Transparency Act (“NATA”) applies to consumers who enroll/participate in individual or fully-insured PPO or HMO plans and their provider networks and requires plans to:
  - Ensure that consumers have timely access to care
  - Maintain an accessible, up-to-date Provider Directory
  - Allow consumers to access OON care at an INN benefit level under certain circumstances (*e.g.*, for emergency care or if plan network does not have right type of provider accessible to render a service the consumer needs)
- IL Department of Insurance (“DOI”) fined BCBSIL for NATA violations:
  - In March 2022 – failure to provide timely notice of material change after terminating network participation of Springfield Clinic
  - In March 2023 – failure to properly: (1) apply maximum time and distance to provider standards; and (2) audit its Provider Directories
  - In November 2023 – failure to update Provider Directories

23 | Practical Considerations for Providers in Negotiating Network Contracts – July 1, 2025

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## Direct Messaging to Purchasers



## Direct messaging to purchasers

### Overview

- Enlisting third parties in negotiating/renegotiating network agreements
  - Self-funded employer plans
  - Members of self-funded and fully-insured plans
- Permissible third party communications
  - If renegotiating, look first to current network agreement
    - Prohibitions on advocating for members to change insurance plans
    - Specific permission to discuss medical decisions, rates paid to provider, and provider's participation status in other networks
  - If negotiating or renegotiating, case law sets ground rules to avoid claims by plan administrator of tortious interference with contract

## Case Law – TPA alleging tortious interference by provider

- *Arapahoe Surgery Center, LLC v. Cigna Healthcare, Inc.*, 171 F. Supp.3d 1092 (D. Colo. 2016)
  - Cigna counterclaim alleged that ASCs' practice of discounting patient cost share amounts and balance bills constituted tortious interference with the insureds' policy agreements with plans
  - ASCs' motion for summary judgment denied – "fee-forgiving" could constitute tortious interference and jury could infer requisite intent by ASCs
- *Kissing Camels Surgery Center, LLC v. Centura Health Corporation*, 2016 WL 8416760 (D. Colo. 2016)
  - Court denied ASCs' motion to dismiss TPAs' counterclaim that mirrored Aetna's in *Arapahoe*
  - Also found that improper referrals by INN physicians to OON facilities could constitute interference with TPA's agreements with INN facilities

## Case Law – Provider alleging tortious interference by TPA

- *Medical Diagnostic Laboratories, LLC v. Health Care Service Corporation*, 772 Fed. Appx. 637 (10th. Cir. 2019)
  - INN providers asked Blue Plan to allow OON lab that offered unique testing services (MDL) to join network
  - Blue Plan responded by telling providers that network agreements required them to refer to INN labs and threatening to terminate providers
  - MDL sued Blue Plan for tortious interference with MDL's prospective business relations with INN providers and Blue Plan members
  - Appellate court affirmed district court's grant of Blue Plan's motion to dismiss
    - Blue Plan letters simply restated INN providers' contract terms
    - Separate defamation count also failed because Blue Plan did not say that INN labs provided exact same services as MDL

27 | Practical Considerations for Providers in Negotiating Network Contracts – July 1, 2025

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27

## Case Law – Other potentially relevant cases (Part 1)

- *Aetna Life Insurance Company v. Huntingdon Valley Surgery Center*, 129 F.Supp.3d 160 (E.D. PA, 2015), affirmed in part and vacated in part on other grounds, 703 Fed.Appx.126 (3rd Cir. 2017)
  - Aetna argued that ASC management company engaged in tortious interference by incentivizing INN physicians to refer Aetna members to OON facilities
  - District court denied management company's motion for summary judgment on tortious interference claim, because issue of material fact existed as to whether INN physicians had breached their network agreements
- *Walnut Street Associates, Inc. v. Brokerage Concepts, Inc.*, 610 Pa. 371 (Pa. 2011)
  - Employee of health plan's TPA (BCI) disclosed to company (Procacci) how much health insurance broker (WSA) was getting paid in commission
  - Procacci fired WSA, which then sued BCI for tortious interference
  - Court found no tortious interference because employee's statement was true

28 | Practical Considerations for Providers in Negotiating Network Contracts – July 1, 2025

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28

## Case Law – Other potentially relevant cases (Part 2)



- In *Aetna Life Insurance Company v. Behar*, 2019 WL 4195355 (S.D. Tex. August 5, 2019), Aetna alleged tortious interference:
  - With its network agreements with physicians by hospital that paid physicians to refer member to OON facility in breach of the agreement
  - With its policies with its insureds by hospital that discounted members' cost share responsibilities
    - Court denied hospital's motion to dismiss on both theories
- In *Aetna Inc v. People's Choice Hospital, LLC, Aetna Inc. v. People's Choice Hospital*, 2019 WL 12536916 (W.D. Tex. March 28, 2019), Aetna alleged that:
  - Hospital and labs tortiously interfered (with hospital agreement) by causing Aetna to pay higher rates in agreement for tests done at outside labs AND (with physician agreements) by paying INN physicians kickbacks to refer to OON labs
    - Court denied defendant's motion to dismiss on both theories

29 | Practical Considerations for Providers in Negotiating Network Contracts – July 1, 2025

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29

## Questions

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30 | Practical Considerations for Providers in Negotiating Network Contracts – July 1, 2025

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30