



Billing & Reimbursement | Revenue Cycle Management

5 STEPS TO BETTER PAYER CONTRACT NEGOTIATION





5 Steps to Better Payer Contract Negotiation

From MediGain's Chief Medical Officer, Eric Beier, MD, MBA

...there are many specialty-specific and practice-specific nuances that physicians need to consider as part of their payer contract negotiation plan.

Contents

- 4** Step 1 – Learn and Utilize General Negotiation Best Practices.
- 5** Step 2 – Perform a SWOT Analysis of the Practice
- 6** Step 3 – Gather Data
- 8** Step 4 – Develop a Payer Contact Matrix
- 11** Step 5 – Develop the Payer Contract Negotiation Goals, Priorities and Plan



5 Steps to Better Payer Contract Negotiation

Eric Beier, MD, MBA

Chief Medical Officer, MediGain

A frequent question I receive from physicians I meet is how they can negotiate better payer contracts. The first answer I give them is that it's not easy – negotiating the best payer contract terms requires a significant amount of preparation and work along with good negotiation strategies. In addition, there are many specialty-specific and practice-specific nuances that physicians need to consider as part of their payer contract negotiation plan. However, in my 21 years in physician revenue cycle management and practice management, I have identified five key steps that generally lead to better payer contract negotiation outcomes. In this article I'll briefly review these five steps, with the goal of optimizing the ability to improve new or underperforming payer contracts given the circumstances and leverage of the practice.



Step 1 – Learn and Utilize General Negotiation Best Practices

At the end of the day, payer contract negotiation is similar to any other major business negotiation, and there are generally recognized “do’s” and “don’ts” to achieve the best negotiated solution. The general negotiation best practices that I have found to be most valuable are as follows:

- 1. Determine if a negotiated solution is needed.** Sometimes one or more issues can be better resolved with customer or technical support options rather than a new contractual relationship. Also, make sure that denials, pre-authorization hassles and lower reimbursement are not due to problems within the billing department of your practice. Finally, be certain that a new contract will be advantageous. With payer contracts, I have seen instances where an existing contract pays higher fees than the payer is offering with new contracts, yet the better paying fee schedule flies under the payer’s radar for a small practice (thus, you may not want to bring this issue to their attention).
- 2. Avoid an adversarial attitude.** As difficult as it may be, approach the negotiation as an opportunity to find common ground and shared interests which lead to a mutually agreeable (although imperfect) solution. Even if you are negotiating with the provider relations person for Evil Empire Payer, show him/her respect, keep the atmosphere friendly, build credibility and build a relationship. Also, try to understand the key wants/needs of your negotiation partner, and look for creative solutions and low-cost “wins” that you can give them in return for something of importance you want.

3. **Good preparation is essential.** Do your homework and identify your key goals, priorities, and leverage for the negotiation. You also need to have a clear (and realistic) understanding of “what does success look like.” Research and understand all you can about the person and company you will be negotiating with, find precedents that may apply (speak with other practices who had successful or failed negotiations with this payer), and anticipate what the key goals, priorities, and negotiation positions will be for your negotiation counterpart. (These may be very different for a new entrant payer in the market versus the “big gorilla”.) Also, identify your best alternative to a negotiated solution, and if/when you will walk away from the negotiations.
4. **Selectively share information.** Revealing a piece of information that is small or can’t be used against you may help to support your case and build trust with your negotiating partner. Sharing information also invites reciprocity from the other side to share information.
5. **Rank order issues.** Identify and rank order in importance both your issues and your negotiation partner’s issues. This helps each side in the negotiation understand the key interests and priorities of their counterpart, identify mutually beneficial trade-offs, and promote the creation of a win-win solution. Ask open-ended questions and play with hypothetical situations to learn the other side’s priorities and to bridge differences. This probing is the key that will uncover potential opportunities for compromise over what may appear to be vast differences between the parties, and also create openings for you to persuade your counterpart on the merits and shared benefits of your position.
6. **Consider making the first offer.** Studies have shown that more often than not, negotiators who make the first offer come out ahead. The reason is that the first offer (if backed by a legitimate rationale/evidence) serves as an anchor and sets the tone for the negotiation. In addition, making the first offer signals strength and confidence, and creates opportunities for making concessions. Also, if the other side makes the first offer, don’t make a concession without getting something in return.

Step 2 – Perform a SWOT Analysis of the Practice

In order to identify your negotiation leverage (or lack thereof) and opportunities for shared benefit, start with a SWOT analysis (strengths, weaknesses, opportunities, threats). In particular, look for the following:

Strengths/Opportunities = Positive Negotiation Leverage

- Practice location(s) and convenience for patients
- Less/Low competition from other providers of the same specialty
- Any sub-specialization or specialized training of the provider(s), and any specialized services offered
- Existing hospital, other physician practice, and employer relationships that can be leveraged
- Good patient satisfaction data to share
- Good quality/outcomes data and metrics performance to share
- Sources of physician power in negotiations include:
 - o Clinical expertise
 - o Differentiated services/offerings from competitors
 - o Knowledge (precedents, payer issues/needs, payer performance on HEDIS payer quality measures, and practice data on payer performance compared to other payers)



- o Goals and positions which are in line with a higher cause (quality of care) or higher authority (CMS guidelines, specialty society guidelines, FDA or regulatory guidelines, etc.); always try to frame your position as taking the high road for patient care and compliance

Weaknesses/Threats = Negative Negotiation Leverage

- Solo or small practice in an area with multiple other providers of the same specialty
- No data or poor data on patient satisfaction and quality metrics
- No data or legitimate rationale for a negotiation position(s)
- No differentiated services or benefits offered (perceived as a “commodity” provider)
- Drains of physician power in negotiations include:
 - o Negotiation attitude/positions of “it’s all about me”
 - o Lack of knowledge and/or lack of discovery questions and probing of negotiation partner desires
 - o Lack of interest or creativity for finding common ground and shared benefits

Step 3 – Gather Data

The old adage is “knowledge is power”, and that certainly holds true in payer contract negotiations. In addition to researching the payer(s) you plan to negotiate with, the provider relations specialist(s) you will meet with, your local market and precedents, and your SWOT analysis points of leverage (or not), you also need to gather and analyze data gathered from your practice. Ideally, I recommend gathering the data as noted below:

1. Patient Quality Data

- Patient satisfaction scores. If you have patient satisfaction survey data from your practice, compile it into a format you can share that highlights how satisfied your patients are with key aspects of the practice. If you don’t have patient satisfaction data, or if you don’t like your current data, perform a patient satisfaction survey prior to initiating the payer contract negotiations. Example patient survey forms and sampling methodologies can be found on the Internet, and the cost of conducting and compiling the survey is low.
- Nonconfidential quality scores from other payers. Don’t assume that the payer you are negotiating with has quality data on your performance. If you have favorable PQRS data from CMS, Healthgrades data, etc., consider sharing it to help substantiate that you are a high quality (and therefore desirable) provider for the payer to add or keep in their provider network.
- Nonconfidential patient case studies or testimonials. Hospitals frequently share patient testimonials in their advertising. If you have a good patient success story, a well-known and respected patient (athlete, business or political leader, etc.), or a patient who you believe will positively showcase the value and advantages of your practice, consider approaching them for approval of a written, radio, or TV testimonial. (Contact your legal counsel to ensure you appropriately document the patient’s approval and ensure you abide by all HIPPA and patient privacy regulations.)
- Hospital Quality Data. If you perform procedures at a hospital, they will likely have quality data on your complication rates, on-time surgery rate, etc. If this data is positive and helps paint a picture of you and your practice as a high quality provider, ask the hospital for permission to use this data in your payer contract negotiations.
- Internal Quality Data. While not as valuable as objective or third party data that allows

comparison to other providers, internal data can still be valuable if it highlights the practice's attention to quality and continuous improvement. The internal data may include compliance fidelity with specialty society or CMS guidelines for certain diseases/ conditions, utilization of disease registries, or internal tracking of patient outcomes/ metrics. This data could even include something such as compliance of patients with care plans (for example, a cardiology practice that monitors and proactively manages the percentage of patients with atrial fibrillation that take their prescribed anticoagulant therapy to reduce the risk of stroke and death).

2. Payer Quality Data

- a. Payer Quality Reporting. The Health Effectiveness Data and Information Set (HEDIS) is a tool with 81 measures used by 90% of health plans to evaluate their performance on dimensions of care and service. Identify the measures that apply to your practice, and how your practice can help the payer meet or exceed the requirements for these measures.
- b. Payer Fee Schedule Comparison.
 - i. Develop a matrix of the top 10 payers for the practice which lists and compares fees for the top 25 CPT codes for the practice. On one Excel spreadsheet load the raw expected contractual fee for each payer for each CPT code. Highlight in green the top 3 fees for each CPT code, and in yellow the bottom 3 fees. The green fees become the benchmark to aspire to for other payers, and the yellow fees become targets for improvement in payer contract negotiations.
 - ii. On a second Excel spreadsheet, convert each of the fees above into a percentage of the Medicare fee by dividing the payer's fee for each CPT code by the Medicare fee for that CPT code and converting to a percentage. Medicare fees are easily available online, and Medicare is an important benchmark payer for most practices. By comparing private payers to Medicare, the practice can identify underperforming payers and more easily see and compare the degree of payer underperformance for key CPT codes.
 - iii. Once important CPT codes with low fees by the contract negotiation payer have been identified, develop a blinded comparison of the contract negotiation payer's fees to blinded examples (Payer A, Payer B and Payer C) of the 3 best payers' fees for each of these CPT codes. To prioritize CPT codes for fee re-negotiation, you can then model the revenue impact of fee increases to a "green fee" for each of these codes using the annual estimated unit volume for each CPT code. This in turn will allow you to identify which CPT codes you prioritize for the best fee increase, and which you are willing to potentially offer as a concession to the payer for little or no increase (or even a fee decrease for rare or low value CPT codes).

3. Payer Reimbursement Performance Comparison

- a. Denials Rate. Identify the payer's denial rate compared to other payers and the MGMA Better Performing Practice rate of 4%. Identify the top 3 – 5 denial reason codes and unit volume for the payer, and the root cause(s) of the denials (payer issue vs. practice issue). If a payer problem(s) is identified (such as difficult or slow pre-authorization process), estimate the annual dollar value and add it to the negotiation priorities list.
- b. Days in Accounts Receivable (A/R) and Percentage of A/R > 90 Days. Compare the days in A/R and percentage of A/R greater than 90 days to other payers. If the targeted

payer's performance is out of line with other payers or the practice's goals, identify the root cause(s) (payer vs. practice issue). If a payer problem(s) is identified (such a high frequency of "claim not received" errors), calculate or estimate the annual dollar value and add it to the negotiation priorities list.

- c. Expected Payments Performance. Work with billing staff or the billing provider to identify partial payment and underpayment issues. Try to identify specific CPT or diagnosis codes, types of services, service locations, and/or code combinations that may be receiving inappropriate claim edit and/or other payment reductions. If a problem is identified, calculate or estimate the annual dollar value and add it to the negotiation priorities list.
- d. Coding and Bundling Issues. Some payers re-sequence multiple procedures from what was submitted in order to pay lower fees on the highest value codes when multiple procedures are billed. The practice first needs be sure its billing/coding staff are sequencing these codes correctly and using modifiers correctly to maximize payment for the highest value codes. If problems are identified, calculate the annual dollar value of each and add them to the negotiation priorities list.
- e. Hassle Factors. Some payers are simply difficult for the billing and other staff to deal with, including but not limited to issues such as long wait times for provider relations or pre-authorization calls, difficult pre-authorization process or requirements, extra work required for resolving claims denials or partial payments, etc. Talk to your billing staff or billing provider to get their feedback on key billing challenges, reimbursement concerns, and hassle factors related to the payer. Estimate the relative cost/benefit of resolving these issues and add them to the negotiation priorities list.

Step 4 – Develop a Payer Contact Matrix

A good practice for managing payer contracts is to develop and maintain an updated matrix of key terms and performance ratings for at least the top 10 payers for the practice. A payer contract matrix allows the practice to compare payer contracts on key terms on an ongoing basis, to have key contractual information easily available when problems occur, and provides a readily available and easy to use reference for the practice manager and office staff to use to abide by contract terms and plan for contract renegotiation. The payer contract matrix elements for each practice may vary based on practice-specific issues such as specialty, payer mix, and the business strategy and goals for the practice. The payer matrix needs to be kept manageable as a quick reference, so I recommend keeping it to 2 – 3 pages maximum and point to reference documents as needed for more details.



In order to help compare payers on different elements, I recommend that the practice develop a 5 or 10 point rating scale for key elements of payer performance and comparison to aid in identifying payers and issues for contract negotiations. In my five point scale 1 = easy/excellent, 3 = average, and 5 = difficult/terrible. In general, I recommend the following elements for a payer contract matrix (see example template on next page):

- **Contract renewal date.** If the practice desires to renegotiate a payer contract, the preparations and negotiations should begin at least 90 – 120 days in advance of the renewal date.
- **Fee schedule revision.** Is the payer allowed to unilaterally revise their fee schedule prior to the contract renewal date? If so, what is the notice required to the practice and what options does the practice have to respond to the proposed fee changes.
- **Termination provisions.** Is there auto-renewal of the contract unless one party gives advance notice to the other? What is the advance notice period? Is elective termination allowed, and if so, what is the notice period? Is termination for a material breach allowed, and if so, what are the key conditions and requirements. Also, consider if the practice potentially can utilize any of these provisions against the payer for leverage and to initiate a contract renegotiation discussion prior to the renewal date.
- **Timely filing requirement.** What is the payer’s requirement for timely claims submission? This provision may be particularly important given the potential delays in identifying ICD-10 coding/ documentation problems, getting these problems fixed, and then submitting the claim within the required time limit.
- **Refund request time allowance.** How far back is the payer allowed to go to request a refund for a previously paid claim? Many payers are hiring firms to do post-payment reviews of paid claims. The practice needs to ensure it is aware of this time limit and consider contesting payment of a refund that is outside this time limit. The practice also needs to ensure it maintains all documentation necessary to review a requested refund for appropriateness, and consider contesting the refund request if it is not appropriate.
- **Denials rate.** I recommend that a physician practice should identify its overall payer denials percentage, and also the denials percentage for each key payer to compare payers to each other, the practice’s overall denials rate and the MGMA Better Performing Practice denial rate of 4%.
- **Medical policies.** I recommend that medical practices provide an overall rating of each key payer on their medical policies per the scale noted earlier. This is a subjective rating, but still allows a quick overview of the perceived difficulty, narrowness and time/cost to the practice of adhering to the medical policies of different payers. In order to keep the payer contract matrix from getting to large and complex, this box can simply be a rating and refer by abbreviation to key medical policies, local coverage determinations, and national coverage determinations that are important to the practice and maintained in a separate matrix or reference location.
- **Prior authorizations.** Same as medical policies.
- **Fee schedule rating.** Refer to Step 3 and provide an overall rating of each payer’s fee schedule.

- **Charge percentage of payer mix.** In order to help rate the relative importance of each payer to the revenue performance of the practice based on services rendered, it is a good idea to identify the percentage of charges that the payer comprises in the overall payer mix for the practice. The charge percentage gives a readily available means to judge the relative amount of services rendered for the payer, and includes services that may don't have RVUs such as lab tests rendered by the practice.
- **Payment percentage of payer mix.** In order to help rate the relative importance of each payer to the cash flow performance of the practice, it is good to identify the percentage of payments that the payer comprises in the overall payer mix for the practice. The total payments for each payer is generally available in most practice management systems, and helps to identify both "good" payers (cash flow percentage generated is higher than the charge percentage for the payer) and "poor" payers (payment percentage is less than the charge percentage for the payer).
- **Reimbursement Performance.** Utilize the payer reimbursement information from Step 3 on issues such as days in A/R, A/R > 90 days, coding/bundling issues, expected payments performance, and hassle factor to generate a rating for the payer's reimbursement performance.
- **Credentialing.** It is important to understand the key requirements, difficulty, and likely timeline required for credentialing new providers for the practice. Also, note if the payer will backdate the effective date to when the provider started at the practice if the payer provider number has not been issued at the time the provider starts working at the practice.
- **Other.** Add any additional elements that need to be brought to the attention of the practice's leadership for managing services for one or more payers and re-negotiating contracts for one or more key payers

Example Payer Contract Matrix Template

Contract Element	Payer A	Payer B	Payer C	Payer D
Renewal Date				
Fee Schedule Revision				
Termination				
Timely Filing				
Refund Request				
Denials Rate				
Medical Policies				
Prior Authorizations				
Fee Schedule Rating				
Charge %				
Payment %				
Credentialing				
Reimbursement Perf.				
Other				

Step 5 – Develop the Payer Contract Negotiation Goals, Priorities and Plan

It has been said that if you don't know where you're going, any road will take you there. This concept is certainly true for payer contract negotiation. If you don't invest the time and effort to do your homework and determine the results you want to achieve before the payer contract negotiation begins, it is unlikely you will get the best result. After you have completed Steps 1 – 4 as noted previously, you are now ready to identify your target list for payer contract re-negotiation, and your plan to achieve meaningful results. I recommend proceeding as follows:

1. Identify the payers you determine it is appropriate to approach for payer contract negotiation. Rank them in order of importance and time frame for commencing the negotiations based on the renewal date, material breach or other problems, or new opportunities. If it is possible (and you have the bandwidth on your team), seek to engage in a “horse race” of negotiating individually (and confidentially) with multiple payers at the same time. This will allow you to get results sooner than doing negotiations in sequence, and potentially allow you to apply learning from one payer contract negotiation to another.
2. For each payer, identify the top 3 goals to be achieved (for example: increase selected fees to X% of Medicare, reduce prior authorization hassles, and increase patient referrals). For each goal, list at least 3 specific results you would like to achieve and rank order them. Also identify “nice to have” results you would like to achieve from the previously discussed issues list, along with things you might be willing to give up in return for a key “win” (for example, offer to lower fees on CPT codes with little volume or value to the practice). These items will become your negotiation focus areas as well as your bargaining chips for creative solutions.
3. Develop your folder of supporting data, precedents, evidence, argument logic/rationale, and potential opportunities for mutual benefit/growth. This is the data and information you will utilize (though not necessarily share) to persuade the other party. Also identify non-confidential information or data that you may be willing to share at the appropriate time with the payer to help support your case.
4. Identify the person(s) from the payer you will be negotiating with, and organize a “cheat sheet” or notes from your research on their likely negotiation positions and goals, and your response/offer to address them.
5. Develop the agenda for your first meeting of the negotiations. Plan to send the meeting agenda in advance. Be sure to include a line item for action items, person(s) responsible, and timeline for resolution for each item.
6. At the meeting, diplomatically lead (and return as needed) the discussion to your key issues. Avoid tangential or philosophical discussions that lead down a blind alley and waste valuable time that could be used to resolve differences and find solutions. Be sure to not leave the meeting without first clarifying the next steps, who will do them, and when they will be done.

Summary

In this article I have provided an outline for managing payer contracts effectively and negotiating a payer contract. For small practices with limited time and resources, it may not be possible to do everything to the degree I have suggested. However, I believe it is still essential that even solo practices follow the same five steps, and do as much as possible for each step to put yourself in the best position possible to gain meaningful results. The bottom line is that in negotiations, “knowledge is power” and planning is essential.



About MediGain

MediGain is a full-service revenue cycle management and healthcare analytics company devoted to improving billing and reimbursement for healthcare providers across the United States. MediGain provides a full suite of billing, reimbursement, credentialing and coding services to physician groups, provider networks, ambulatory surgery centers and hospitals. In addition, MediGain has industry leading proprietary business intelligence and predictive analytics that help their clients run the business of their practice. For more information on how MediGain can maximize revenue, reduce expenses and allow you to spend more time providing your patients with quality healthcare, visit our website, www.MediGain.com; call us at 888-244-4754 or email marketing@medigain.com.



2800 Dallas Parkway, #200
Plano, Texas 75093
www.MediGain.com | 888-244-4754