Get exactly what you want from your next contract

Set yourself up for successful payer negotiation

Executive summary

Time to raise the bar on internal and payer communication

It's no secret that the health care landscape is changing. Mergers and acquisitions, accountable care principles, Medicare cuts and value-based payments are just a handful of the multifaceted changes stressing the bottom line at health systems across the country today.

Therefore, the responsibility of health system finance leaders to maximize contract value is more complex than ever. As a result, best-practice organizations are getting the most out of their contract yield and improving contract management by:

- Increasing internal communication and coordination
- Opening regular communication channels with payers

It's time to ask questions, analyze payer trends, understand your specific opportunities and financial numbers, talk about market impacts, set clear objectives and ensure your contracts align with organizational objectives. Once your internal team agrees, you can be transparent with payers and know where you can be flexible and where you need to hold strong on contract terms.

Come together as an internal team to know what you want out of a contract and then do the prep work to **get what you want** when you speak to payers.

Lay the internal groundwork for success

The key to success is communication

Payers know exactly what they want when they sit down for their next negotiation. Do you?

Active internal participation and actionable strategic direction are the foundation for success when managing payer contracts. A strong internal team ensures that you'll begin to prepare with enough time to avoid surprises at the negotiation table.

Getting input and agreement from key stakeholders at your organization ensures you ask the right questions during negotiation, are flexible where you can afford to be and are more stringent on the terms that yield the best outcome for your organization. Internal contract meetings are a chance to establish net revenue targets, discuss corrective measures for any past internal or payer contract issues and anticipate the response to proposed payer changes.

Active participation from key stakeholders

- Financial leadership
- Patient accounting experts
- Physician representation

Actionable strategic direction

- Establish revenue targets
- Correct issues
- Anticipate responses

Get your house in order before you go to the negotiation table

Organize a committee of stakeholders

Good internal communication across the organization means organizing a committee that includes key stakeholders such as financial leadership, patient accounting experts and clinical representation. This committee is in charge of reviewing your portfolio of contracts and of constantly monitoring, improving and setting your strategy going forward.

Stakeholders should **meet monthly or quarterly** to understand payer performance. Best-practice organizations hardwire this habit into their schedules throughout the year — **not just before a negotiation is due**. The benefits of being totally coordinated before speaking with payers cannot be achieved any other way.

At these meetings, you should calculate your contract yield, compare expected to actual yield, review service-line figures and understand overall financial numbers.

Compare expected to actual yield

It is critical to compare the expected yield from a contract to what you are actually being paid. The key question to ask before a negotiation is whether the variance between actual and expected yield is in an acceptable range. Many contracts do not reach their expected yield; the higher the variance, the more you need to dig into that contract.

Second, the committee must assess whether the actual yield for each contract is in line with the contractual allowance budget that is part of your organizational financial plan.

Third, your stakeholder team should compare actual yield across contracts and plan to minimize the variance in actual yield across top-tier contacts.

Review service lines

After you have reviewed the aggregate data, you should look at contract yield at the service level to really understand how specific services affect a contract's overall reimbursement structure. To get the best assessment, compare performance across contracts with similar patient populations only. If a service line is not performing well, speak with the clinical manager of that service line to understand where the differences originate. Together, you can better understand the patient population and how your organization should think about contracts for that particular service area.

Understand your financial position

Your team should review financial numbers every month with a team from finance and managed care (and your service lines as appropriate). Understanding overall performance will allow you to challenge the numbers when appropriate and ask questions about what is going on with various contracts. This constant organizational communication and feedback loop sets you up for the next round of negotiations. You are a team, and as a team you have to understand the data together to plan what you want to get out of payer negotiations.

Go the extra mile: Know improvement opportunities and contract weaknesses

Use data to formalize the negotiation process

When a negotiation is approaching, it is crucial to review data of past contract performance, identify contract vulnerabilities and solidify your negotiation strategy upfront so that your team is prepared.

First, **review past performance** to see how expectations matched actual outcomes. If something did not turn out profitably, then you can work to correct it during the next round of negotiation. Ask yourself:

- Were last year's revenue targets realized?
- Did overall patient utilization match our expectations?
- Was there an unexpected increase or decrease in services rendered?

Second, every contact has vulnerabilities, so you should **know the vulnerabilities** and market conditions that impact each contract. Payers tend to follow one another, so if you see one payer making a particular move, then other payers are likely going to follow that same reimbursement methodology or contract provision. Ask yourself:

- Were some services more susceptible to variances than others?
- Are there market changes that alter current methodologies? (e.g., APR-DRGs, EAPGs, APCs, etc.)

Finally, your internal team must **align your negotiating strategy with organizational objectives** to ensure that contracts support your organizational objectives. Having an understanding of what the payer is likely to ask for, and your organizational goals, will help you determine where you need to hold strong and where you can compromise a bit. Ask yourself:

- Is our strategy aligned with organizational objectives?
- How will we respond to anticipated payer proposals?
- What are the areas we can compromise and where will we hold firm?

Three rules for negotiation success

A clear plan is the best plan

Best-practice organizations plan for contract negotiations **three to six months** out and follow three rules to elevate their success.

1. **Define the baseline population.** One of the first things many organizations do is set the baseline patient population for proposal iterations with specific date range, payers and services.
2. **Establish clear objectives of what you want to achieve out of negotiation.** Do you want specific net yield increases or an increase in a specific service line? Is greater accountability your main goal, or is it stronger contract language for late or inaccurate payment? Make your objectives known to the payer upfront. There is value in letting the payer know that you have expectations about what you want to achieve during the process.

3. **Anticipate as many changes as you can, and plan for them.** For instance, brainstorm methodology changes that might come from the payer, or anticipate language changes that you want to make for chargemaster increases or payment discrepancies. If you are looking at a longer-term contract, think about a price adjustment or index you and the payer can agree on.

Set up regular communication with payers

Get the ball rolling: Speak with payers regularly

We recommend speaking with payers **monthly or quarterly,** depending on the size of the contract and the payer. These meetings serve to identify problems that come up after a negotiation round. For instance, after you start receiving reimbursement on a contract, you might discover some ambiguous contract language. Your team can use these meetings to amend the contract or at least set the stage for the next negotiation that could clean up reimbursement terms and methodology.

It is important to have these meetings 30, 60 and 90 days after you execute a new rate schedule or new contract terms. If there are problems, it is a lot easier to adjust them right away than to wait a year or two for the next negotiation. Monthly meetings with payers keep communication channels open, allowing you to talk about what is going on at your organization and prompting the payer to discuss what they see in the market. The more cooperative you are in these meetings, the more you are able to transition the discussion into talking about market trends and other changes coming down the pipeline.

Hold payers accountable for executing on appeals

Dig deeper into your appeals

Monthly payer discussions are a great time to discuss appeals. Look at appeals you have submitted and see which got paid, rejected and received no response. In order to achieve contract yields built into your budget, you need to execute on underpayments and denials, and get as many dollars back in the door as possible. If necessary, you should go claim by claim with the payer to make sure appeals get resolved, to prevent your organization from carrying large payment discrepancies for a long period of time.

Ask yourself

- **Appeals submitted:** Are areas of the contract being paid less than we expect?
- **Appeals paid:** Are payers paying appeals for the same reasons they are rejecting them?
- **Rejected appeals:** Are payers paying appeals for the same reasons they are rejecting them?
- **Nonresponsive appeals:** Are payers delaying payment on certain types of accounts?

The right tools for the job

Monitor payer trends and prepare for discussion

Getting ahead of trends can be the difference between hitting revenue targets or not, so you must review account trends to find where payers are not paying as expected. We recommend analyzing data on two types of metrics before you speak with payers: those that require end-user intervention (by people who work accounts on a daily basis) and those that don't. These metrics are your tools to have a successful negotiation.

Reporting metrics with end-user intervention:

- Appeal success rate
- Activities per appeal
- Payer appeal response time
- Internal process errors

Reporting metrics without end-user intervention:

- Expected monthly yield
- Specific service-line review
- Time until first payer payment/ AR aging
- Net revenue

Who says you and your payers can't see eye-to-eye?

Rigorous preparation pays dividends

With the right data, you can compare contract changes side by side and understand where your greatest contact opportunities exist. The payer also wins because you reach an agreement faster and prevent disagreements down the line.

Here is a real-life example of a hospital that reaped big rewards from rigorous upfront preparation.

Memorial Hermann Health System, an 11-facility system in Houston, TX, and one of our partners, followed Advisory Board Research's best-practice negotiation tactics and used our Optum® Payment Integrity Compass technology to facilitate the process below. Using this methodology, they reduced their negotiation cycle for a major payer from 30 proposal iterations to seven.

"Through Optum Payment Integrity Compass reporting and accurate model calculations, we had exactly what we needed to be confident in our strategies and decisions during our negotiation."

System Executive, Managed Care

1

Doing their homework

- Understand contract and patient trends 3–6 months before contract expiration date.
- Track contract performance monthly and find terms to increase contract revenue.
- Identify areas to gain payer leverage (market data, payer financials).

2

Opening communication with payers

- Come to an agreement with payer on how a chargemaster increase will impact negotiation.
- Agree with payer on patient population baselines (CY or FY, claims paid or expected payment, inpatient and outpatient volumes).

3

Maintaining a firm stance with data

- Utilize Optum Payment Integrity Compass data to validate and support decisions.
- Ensure retail service lines remain competitive and all data sets are accurate (e.g., DRG version changes).

About Optum Payment Integrity Compass

Better, faster and stronger technology

While the capabilities of most payer management systems today are outstripped by current and future reimbursement challenges, Optum Payment Integrity Compass incorporates people, process and technology to help you reach a new level of payer performance.

What makes Optum Payment Integrity Compass different?

Optum Payment Integrity Compass calculates current expected reimbursement, models future contracts, manages underpayments and denials, and provides detailed reporting. While other platforms perform elements of these tasks, we at Optum360 work to ensure that Optum Payment Integrity Compass stands out from other contract management systems in several ways:

1 **Model contracts with precision and speed**

Optum Payment Integrity Compass allows you to achieve unrivaled precision by modeling any rate schedule against any patient population, any chargemaster or new groupers. Efficient processing enables you to rapidly evaluate and iterate on models, enabling real-time evaluation of payer proposals and allows you to design favorable counter proposals.

2 **Boost workflow efficiency to collect more dollars**

Set up rules to detect every known payment issue, group like claims together and eliminate significant manual effort. Appeal claims in bulk and automate the creation of documentation to accompany grouped claims. Our detailed workflow also coordinates seamlessly across departments to overturn more denials and increase underpayment recovery on even the smallest variances.

3 **Powerful reporting and analytics**

Optimize performance by utilizing standard reports designed to identify trends, analyze revenue leakage and assess noncompliance by payer, issue and contractual terms. Available variables (1,900+) include all data elements from your patient accounting system and reports and analyses can be scheduled for regular processing or run on demand.

4 **Dedicated experts drive lasting change**

A broad, deep team of experts ensures rapid results and long-term success. Your team includes an implementation leader, contract analysts, programmers and technical support staff ready to help train users, identify opportunity, drive rapid results, track returns and ensure continuous improvement.

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