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Best Practices for Negotiating Payer Contracts as Cost Shifts from the Payer to the Patient

The only constant in life is change. This statement is very applicable to healthcare reimbursement today, as payer contractual and strategic pricing processes must integrate and evolve.

High-deductible health plans are now commonplace in 2019, a recent trend that requires providers to collect an ever-increasingly higher portion of the cost of care from the consumer. Also, hospitals are now required to post their charges publicly, but this list of retail prices is not easily connected to the consumer's cost.

These shifting dynamics are putting more pressure on hospital executives to set charges, negotiate payer contractual allowables, and provide accurate estimates of cost. The result leaves patients to assume greater financial responsibility than ever before.

Healthcare providers recognize that reimbursement negotiations still take place with the organization's payers, but the patient is quickly becoming a consumer of healthcare services—versus a recipient of services.

Greg Kay, Senior Vice President of Revenue Strategy at PMMC, detailed the ways contract governance is evolving in a consumer-focused, value-based payment system, and outlined best practices for negotiating payer contracts in a recent *HealthPayerIntelligence.com* webcast.

"To facilitate bending the cost-growth-curve, the underlying premise is that consumers must become more engaged with their healthcare expenses, which will translate to a higher level of price shopping," said Kay.

To ensure patients are well-informed of the costs associated with different payers, health plans, and contractual reimbursement, CMS is pushing providers to offer patients transparent access to quality and pricing data. A key requirement will be clearly differentiating charges (the "retail price"); price (the "allowable" or "discount price"); and cost (the "consumer's cost" or "financial responsibility").

"This will be the new normal, and it's going to require new processes, new technologies, and new components when monitoring payer activity; for example, utilizing scorecards to improve negotiating payer contracts," said Kay.

Additionally, healthcare has unique complexities in terms of how providers are paid.

"Patients often don't understand the contractual reimbursement relationship between providers and payers, especially the fact that their insurance company negotiated significant reductions with the 'allowable' or 'discount price,'" said Kay.

"The concept that charges are priced high so that payers (the insurance companies and/or the patient employers) can receive large discounts on paper can be a challenging concept within the industry, and even more perplexing for those outside of healthcare. Other retailers and industries do not operate with such weighty contractual discounts at the very beginning of the purchasing process," he explained.

Accurate payer contractual reimbursement is traditionally viewed as the starting point of the payer negotiation process.

"As we think about these changing consumer demands and the need for accurate allowables (for both modeling and the shift to consumerism/patient price shopping), we have to view the importance of an accurate allowable in a much broader perspective," said Kay.

"As the industry and related revenue cycle processes are changing and evolving, the fact is your charges are now transparent because of the requirement to publish them online," said Kay.

In this new reality, healthcare providers should be revisiting how their charges compare and understand how reimbursement by payer and service line is performing with the consumer in mind. This kind of approach will likely lead to an increase in payer contractual renegotiations.

Kay recommended best practices to address four aspects of payer contract negotiations to achieve accurate allowables: contract composition, performance, expectations for negotiations, and strategy. Every payer contract has an effective date, but if both parties agree, renegotiation can occur anytime.

When examining contract composition, Kay suggested providers identify provisions for initiating negotiations, assess all contract terms and related amendments of the current agreement, and isolate potential additions to current contract provisions.

Kay also suggested providers assess how the payer relationship is performing under the current contract to get an idea of how the payer relationship will function under the new, projected contract.

"If you begin comparing one contract scenario to another, one of the first benchmarks that we recommend is benchmarking the contract against the original projection," said Kay. "To have a true win-win contractual arrangement with the payer, you have to model everything."

The accuracy of the allowable is becoming especially important as patients become a more substantial portion of the healthcare organization's revenue cycle.

"An accurate allowable helps ensure all payers are paying correctly and completely," said Kay. "Money is made when you buy, not when you sell."

Modeling the proposed payer contractual rates and terms with your organization's actual claim data will lead to an understanding of the key variables.

Variables in payer contracts determine how payers and providers will manage and negotiate reimbursement risk through contractual reimbursement methodologies.

To optimize reimbursement rates while negotiating payer contracts, Kay emphasized that before signing, staff should strive to understand the proposed terms included in the contract and the effect these terms will have on revenue.

In shared savings contracts, quality benchmark metrics are directly tied to reimbursement. "Be sure and explore opportunities through the value-based components of the contract to incorporate upside bonus payments for meeting certain defined quality measurements," advised Kay.

Bonus payments earned through shared savings contracts run from one to five percent. Kay recommended that providers proactively discuss value-based options with payers to understand which entities will support a healthcare organization's preferred contractual arrangement.

Contract governance includes contract analysis and modeling, expected reimbursement calculations, variance monitoring workflow, and payer scorecard and reporting.

Implementing best practices to improve contract governance can help healthcare organizations receive timely and accurate reimbursement while providing price transparency to patients. As the healthcare industry shifts from a fee-for-service payment system to a value-based payment system, healthcare organizations are increasingly incentivized to promote care coordination and achieve shared savings for both patients and providers.

One recommended strategy is to incorporate the amount of risk healthcare organizations believe the organization can successfully manage. Best practices recommend that organizations model the impact of the terms with prospective contract modeling software using actual account data, including historical payment receipts.

Providers have to model and know which party (payer or patient) is actually going to pay the negotiated allowable. Otherwise, a projected contract may come up short if providers don't consider the shift to increased patient responsibility.

"Regardless of the methodology, using your historical billing data will provide the ability to understand the net revenue impact by modeling the effective discount rate of the various rates and terms. This allows a side-by-side comparison of one proposed contractual arrangement to another," said Kay.

In addition to payers and providers, Kay emphasized that healthcare organizations should also consider how federal entities and patients will be affected by different contract arrangements.

The industry shift to pricing transparency, healthcare consumerism, and value-based care

will continue to increase the financial responsibility for the patient rather than insurers, who have traditionally negotiated reimbursement rates and terms.

According to PMMC survey data, almost all hospitals currently meet CMS mandates for posting the chargemaster online, but most still offer little transparency to consumers related to their cost of the anticipated service.

CMS is pushing the envelope with a new Procedure Price Lookup tool to help Medicare beneficiaries understand the cost difference between services based on where the service is received. Commercial payers are also offering similar web tools.

Healthcare providers now have to decide if they are going to control the "price" message in their market by proactively offering price estimates to patients where they are—online. Breaking down the organizational and system silos to generate a true integrated charge and pricing strategy in the future is necessary, Kay recommended.

Ultimately, providers need to confirm they have the necessary modeling tools for future contracts and a reliable team to approach grading (i.e., score-carding) performance and negotiating positions moving forward.

"Widespread adoption and the transition to consumerism in healthcare may be a few years off, but the financial impact is gaining speed," said Kay. "Now is the time to begin evaluating your systems and your payer contracting processes."

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