7 STEPS FOR PAYER/PROVIDER CONTRACT NEGOTIATIONS AND RELATIONSHIP BUILDING: INSIGHTS FROM 25 YEARS AT THE TABLE

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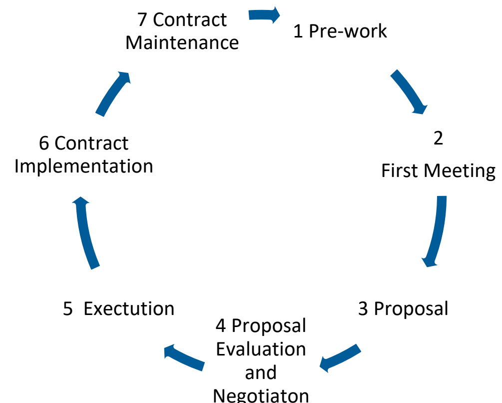
Early in my career, I sat through some nasty, hostile contract renewal negotiations: the big payer shoving the contract and rates down the provider's throat and the largest provider in the market holding that position hostage for outrageous rate increases that were not sustainable for consumers. Bad relationships all around.

Since then, I have seen and contracted everything from percent of/off billed charges to complex risk models and capitation, and have learned a few tricks along the way, mostly through trial and error. Through these early experiences, I developed an approach that leads to much better outcomes and very collegial payer/provider relationships. First, my approach is built on the basic premise that most often, payers and providers need each other in a defined geographic marketplace (there are exceptions) so relationships are key. Second, I believe all of us should conduct business in a respectful manner and consider how we want to be treated in return. We need to build relationships and partnerships, not engage in head-to-head combat. In this article, I outline my approach and provide some strategic tips. In future newsletters we will explore the nuances and issues related to specific contracting methodologies like bundled payments, risk contracts, and others, but for now, let's concentrate on the contracting process.

THE PROCESS AND APPROACH

A solid payer/provider contracting process follows seven distinct steps and the process becomes a continuous circular event, as shown at right. Many organizations and clinical practices live in steps 1, 3, 4, and 5, and even then, step 1 sometimes gets shortchanged.



1. Pre-work

I cannot say enough about this step. This is where you develop your contracting strategy, and it should change as your organization and strategy evolve from year to year.

a. Analyze existing contracts. What has been the financial impact of the contract on your organization? If you are following Step 7, this should be easy by the time you need to get ready to negotiate.
b. Hold internal meetings to identify issues and opportunities. Contracts affect every part of your organization—finance, billing, operations, and yes, the clinicians, especially with any incentive-based contracts. What are the key issues for these stakeholders?
c. Develop a list of what is important to accomplish during this negotiation. What are your objectives?
d. Identify what you want/need from this relationship. How can you improve the relationship so it is more aligned with your long-term objectives? What can you learn from existing arrangements and previous negotiations?

e. Be realistic. The best and most successful negotiations are those where neither party gets everything they want. What is your bottom line or BATNA (best alternative to a negotiated agreement)?

2. *Meet FIRST – Propose and Negotiate Later*

I learned long ago to set up a "meet and greet" meeting prior to exchanging any proposals. It is best to do this at least three to six months before the end of your contract period. Suggest this type of meeting to your top payer(s) and make sure they are on board. I highly recommend the meeting participants from both organizations include the CEO and/or CFO, the VPs of Contracting, the Chief Medical Officers (CMOs), VPs of Quality, and others as particular issues dictate. This is a high-level meeting to set the table and should be done in person. I began insisting that key medical staff executives from both organizations be present, especially if negotiations involved quality and other financial incentives tied to patient care. This is a must. Why this meeting? Because you want to know:

a. Who will be on the payer negotiation team
b. What issues they are trying to solve
c. Their future strategies as a company
d. What is working with the current contract and what is not, from their perspective, both administratively and regarding patient care
e. What do their other market contracts look like—are they moving towards value-based?

It is also a time for you to share your concerns for your organization, some of your strategies, what is working for you and what is not in the current contract and relationship, and any new services you want included in the new contract.

Knowledge is power. It is better to know now where the lines may be drawn. It is also less threatening since the focus is on sharing and listening rather than looking at proposed rates that make everyone see red immediately. It also allows for thinking and creativity. Is there a way to position your negotiation to align with some of the payer's goals? Will the payer reconsider changing some of the burdensome administrative issues if your clinicians agree to some incentive goals or new protocols? The goals for the First Meeting are listen, learn, and share. That is it. Sorry, finance folks.

3. *The Offer*

It is important to decide which organization will take the lead on that first round and determine the timeline. Once the first offer is on the table, be prepared to move quickly into Step 4.

a. Decide which organization will put the first offer on the table based on the conversation at the First Meeting. There are pros and cons to each. The right approach depends on the issues that need to be addressed and the posture of the negotiating parties. For example, if there are methodology changes being proposed, it may be best to have the payer go first since they have more data than you do. Or if, for example, you want to introduce a new program on which you are willing to take risk, you may want to put the first offer on the

table so you control the expectation and the metrics for measuring results. If you are able to provide data and proof of concept, the payer may like not having to do the extra work, so I encourage providers to bring new approaches and programs forward.

b. Set a meeting schedule for the next few months to keep both organizations on task. It is never good to try negotiating with only weeks or days before the contract end date.
c. If you go first, you will lead with your Plan A, which will include everything you want.
d. However, make sure you have already developed Plan B and C and your Walk Away offer (know your bottom line or BATNA as described previously)!

4. Contract Evaluation and Negotiation

Contract negotiations are a bit like playing chess. It helps to anticipate what your opponent will do, and it will be much easier to do so armed with any information gained from the First Meeting.

a. Does the proposal address some of the issues the payer mentioned at your First Meeting?
b. **Does it address concerns you brought forth** at the First Meeting?
c. **What are the terms of the contract—**duration, termination and notice provisions, effective date, calendar year renewal or not, payment methodologies, rate escalators, quality incentives, other standards of service? These details matter a great deal and should be part of your strategy. For example, do you want to have all your contracts to renew at the same time or spread them out so you can give each more attention?
d. **Do the math**. Regardless of whether you make the first offer or you are reacting to one you receive, *do the math.* What is the contract worth in total? If methodologies are changing, it is critical to try and "re-adjudicate" your prior year claims. Does this increase or decrease your reimbursement? If you do not have the resources to do this, consider hiring someone who does or ask the payer to do the analysis and estimate the impact. Some rates may increase, others decrease; most importantly, what is the offer worth to your organization in total? Don't lose site of future impacts if the contract has a lengthy duration. Consider renewal risks if terms require significant investment of time and resources by your organization.
e. **Review all definitions—the more complex the contract or reimbursement methodology, the more important this step becomes.** It has been my experience that 98% of the negotiation/contract confrontations I have seen were due to lack of consensus on definitions; each party had its own understanding of the wording. This can literally make or break the financials of the contract and certainly strain the relationship. If at all in doubt, ask clarifying questions before making a counter-offer.
f. **Define and show sample calculations if necessary**. This becomes most important for complex contracts and where there will be any retro reconciliations required.
g. If you have developed a Plan B and C, they can now be fine-tuned using the financial analysis of the offer on the table
h. If you decide you are truly at an impasse, you may be considering your Walk Away (or BATNA) offer. Never use this approach unless your organization (including the board if this is a large payer relationship) are 100% behind pulling the trigger. **If you use this strategy, "here is my final offer, take it or leave it," you MUST mean it. Use with caution.**

5. Contract Execution

While this is in many ways the easiest step, make sure you and at least one other member of your team read every word of the final contract you are about to sign. Mistakes happen. Some contracts are quite lengthy and have many parts and products attached. The payer may have agreed to something verbally but forgotten to add the change to the final document. Cross-check everything, as you may be living with this arrangement for several years.

6. Implementation

You just signed the contract—congrats! Now you're done for another year or five…right? WRONG. **A contracting process is NOT complete until the contract is implemented** by both the payer and the provider.

a. Really learn and train the staff on all key aspects of each contract. Again, knowledge is power and will assure best outcomes.
b. Payers need to load the contract into the system, test the setup, and make sure they meet the effective date of the agreement so claims will adjudicate correctly.
c. Your finance, coding, and billing offices need to know what to expect for reimbursement and systems updated. If any of the contract methodologies changed, it may mean changes to your entire coding and billing process and system.
d. The clinical staff must know if there are incentives built into the contract or if this a risk type contact. You will not succeed unless they were part of the negotiation team and the organization takes operational steps based on the contract terms. Risk sharing and quality terms should not be surprises to the clinical staff.
e. Make sure you check the fist set of claims submitted and the corresponding remittance after the effective date of the new contract. Make sure it matches your expectation. Mistakes happen. **Don't assume the payer got it all right.** If what you are seeing is in any way different than expected, call the payer immediately. Fixing things retrospectively rarely ends well and is at best painful and administratively expensive.

7. Contract Maintenance

Your revenue depends on your contracts, so why would you just file them away? Best practice, even for evergreen contracts, calls for **a review *at least* annually**.

a. **Contracts are living agreements.** They can affect every aspect of your organization, especially as you move closer to value-based reimbursement models. Even small things should be checked. For example, did you agree that the fee schedule will increase by X% each year of the contract? You need to ensure that happens. You should also be certain to analyze the new fee schedule against your current billed charges, as you do not want to trigger the "lesser of" clause in the contract.
b. **Review large or complex contracts quarterly** so that issues can be addressed. If the issue is severe enough, it might warrant an amendment to the contract.
c. Your business changes during the life of a contract as well. **Communicate changes.** Make sure if you add locations, retire physicians, add services, change hours of operation, etc. that

the payer knows immediately. **Your contract or your provider manual obligates you to do so, and failure to do so can impact your patients negatively.**

d. Better to **address issues as you go,** or you will have a long list for the next negotiation. These issues tend to fester and cause mistrust and other difficult feelings that get brought to the next negotiation. Remember, part of what you want to foster is a good working relationship with the payer.

Contracting is a complex, time consuming, and often fraught undertaking. While the above steps provide a solid framework to follow, it still helps to have a sounding board. Even if your organization checks many of the above boxes in your approach to contracting with payers, consider an objective, third-party review of your contracts and contracting strategy periodically. We recommend such a review at least every three years if there are no major disruptive market forces, but this type of review makes sense whenever you wish, or a payer pushes you, to make major shifts from the current approach or if there are major shifts in your market environment.

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