REVENUE CYCLE MANAGEMENT

Healthcare Contract Negotiation: Data points that strengthen your negotiation position at renewal time

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After leaving contract terms and rates to payer control for years, provider organizations are finally taking a more assertive stance in healthcare contract negotiation.

Stagnant or slow-growing reimbursements in an environment of rising operational costs generate a margin squeeze that makes contract negotiation imperative.

Sharing that inpatient claims denials have doubled in the last three years, Mount Sinai Health System chief managed care officer Brent Estes asserts that providers must fight back.

Daniel Morrisette, CFO of multi-state, nonprofit Catholic healthcare system CommonSpirit agrees. She warns in a recent *Becker's Hospital Review* article,

> "the gap between [provider] revenue growth and expense increases is unsustainable...It's difficult to see a viable path forward without increases in per-patient reimbursement rates."

And a recent Boston Consulting Group study concludes,

> "Hospitals that have traditionally just taken whatever rates payers will give them can no longer afford inaction. The typical health system needs a rate increase of 5% to 8% each year across all payers to break even by 2027."

If that prospect feels intimidating, know that you have something powerful on your side: contract data.

By documenting concrete reimbursement rates, revenue distribution, payment variances, payment terms, and more, healthcare organizations can build a strong case for improved contract conditions. This data helps free you from accepting payer-generated data that is potentially skewed in their favor.

Here you can review the most impactful data points for healthcare contract negotiation that support a stronger negotiating stance with payers. These insights will help you identify opportunities for improved terms and demonstrate your practice's value at renewal time. By understanding and leveraging this information, you can approach contract discussions with increased confidence and clarity.

What is Healthcare Contract Negotiation?

Healthcare contract negotiation is a vital process in revenue cycle management where providers secure fair and reliable reimbursement agreements with insurance companies and other payers.

This process involves reviewing and refining the terms of financial contracts to ensure they align with the organization's operational costs, revenue goals, and commitment to patient care. Negotiations often cover reimbursement rates, payment timelines, covered procedures, and performance expectations. The ultimate objective is to craft agreements that support both patient care and the provider's long-term financial stability.

Successful healthcare contract negotiations require more than just financial discussions—they depend on a deep understanding of robust analysis of past payment data, market trends, and a clear presentation of the provider's value. Because providers have grown accustomed to controlling the negotiations due to several factors, it takes concrete data to get their attention and drive change.

Data points that move the needle in healthcare contract negotiation

Current reimbursement rates by payer

Too many provider organizations do not have a clear view of contracted rates. When MGMA asked medical group leaders how often they review payer contracts, 58% said they conduct reviews annually, while 16% selected "other"—indicating reviews occur every two years or less often.

Strikingly, 17% reported never reviewing their contracts.

This mirrors what we see with our clients: many haven't looked at their contracts for five years or more, and one hadn't seen them in 12 years. Provider organizations may struggle to get copies of their agreements from payers. (Best Practices for Contract Management guide covers how to request updated contracts and more.)

Providers' lack of awareness of contracted reimbursement levels enables payers to take advantage, underpaying sometimes by millions of dollars. When one orthopedics management services organization

conducted careful contract analysis, it found 10.3 million in underpayments.

Knowing your negotiated rates for each payer helps you:

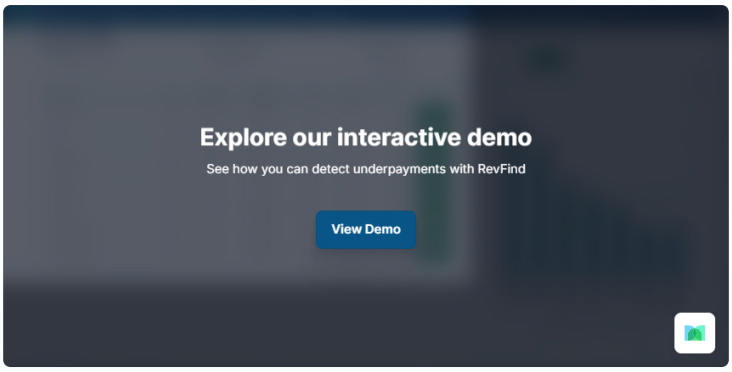
- Identify and contest payment variances, denials, and underpayments that sweep in earned revenue.
- Present hard evidence of unpaid or underpaid claims to strengthen your negotiating position for higher, more consistent rates.
- Secure annual escalators and protections against sudden payer-driven amendments that would reduce rates.
- Benchmark against market standards.
- Enter contract negotiations fully informed.

Use these action steps for documenting reimbursement rates:

1. Gather all current contracts and fee schedules from each payer for your top codes and services.
2. Create a fee-analysis spreadsheet or use contract management software to centralize contract details, rates, and terms.
3. Map reimbursement rates by payer and CPT/DRG code, noting variations or discrepancies across payers for identical services.
4. Benchmark your reimbursement rates against Medicare Fee Schedule amounts, converting private payer rates into percentages of Medicare for standardized comparison.
5. Identify underperforming contracts or services where rates fall below internal targets or market benchmarks.
6. Regularly update your database or software with new rate information following each contract renewal, amendment, or notice of fee schedule change.

While you can conduct this work manually, automating these steps with an automation-supported contract management platform reduces manual work, ensures accuracy, and positions providers to negotiate from a data-driven, advantageous stance.

Take a quick, self-guided tour through a powerful contract management tool that optimizes contract performance, denial management, and payer reimbursements.



Service volume by CPT codes

Highlight your most utilized, revenue-generating procedures. This information empowers you to focus negotiations on the procedures that generate the most revenue for your organization, allowing you to secure better reimbursement for the work that matters most. Payers often manipulate contracts by offering relatively favorable rates for services you bill infrequently, while keeping lower reimbursement for your high-volume procedures—resulting in little real financial benefit for your practice.

With these figures, you can:

- Identify your highest-value services. Justify requests for better reimbursement rates for them.
- Demonstrate your organization's financial impact to payers.

Use these action steps for determining service volume by CPT codes:

1. Extract billing and claims data from your practice management or EHR system for the desired timeframe.
2. Filter that data to list all CPT codes billed by your organization.
3. Count the frequency each CPT code was billed, aggregating across all providers and locations if applicable.
4. Calculate associated revenue for each CPT code by multiplying unit volume by the paid (not billed) amount.
5. Sort and rank CPT codes by total volume and total revenue to identify your most utilized, revenue-generating procedures.
6. Review your ranking periodically to account for seasonal trends and shifts in service mix.
7. Present these insights in summary reports or dashboards to support strategic planning and contract negotiations.

By routinely analyzing and presenting this data, you stay prepared to advocate for better rates and strategic growth during contract renewals.

Revenue distribution among payers

Prioritize negotiations according to which payers contribute most to your revenue.

With this data, you can:

- **Identify** which payers have the greatest impact on your organization's bottom line.
- **Prioritize** negotiation efforts toward payers contributing the most revenue.
- **Highlight** potential overreliance on specific payers, guiding risk mitigation and diversification strategies.
- **Equip** you to tailor proposals and negotiation tactics based on each payer's relative importance.

Here are the steps to determining revenue distribution among payers:

1. **Extract revenue data:** Gather payment and posting data from your billing or practice management system for your selected reporting period (e.g., last 12 months).
2. **Identify payers:** List all payers (commercial insurers, Medicare, Medicaid, self-pay, etc.) included in your organization's revenue streams.
3. **Aggregate collections by payer:** For each payer, sum the total payments actually received (not just billed charges) during the period.
4. **Calculate total revenue:** Determine your organization's total patient care revenue for the same period.
5. **Calculate Revenue Share:** For each payer, divide the payer's total payments by your total revenue to determine their percentage contribution.
6. **Rank payers by revenue share:** Sort payers from highest to lowest based on their share of your total revenue to see which drive the largest portion of your business.
7. **Visualize the distribution:** Present the revenue distribution in a summary report, table, or chart for clear visibility and strategic planning.
8. **Review periodically:** Repeat this analysis regularly to capture shifts in payer mix, identify emerging trends, and adjust negotiation priorities as your revenue landscape evolves.

A clear understanding of revenue distribution among payers enables your organization to negotiate with focus and confidence, concentrating efforts where they will deliver the most value.

Payer contract performance

Compare each contract's reimbursement rates and contract terms to the others in your payer mix as well as to regional, national, and specialty-specific market benchmarks, including Medicare and peer organizations.

It takes this data to:

- Identify your best and worst payers.
- Identify gaps between current reimbursement rates and market standards to support well-founded requests for higher payments.
- Identify and detect underpayments.
- Demonstrate to payers how proposed rates align with—or lag behind—regional, national, or specialty-specific trends.
- Find the payers with the highest denial rates.
- Demonstrate to payers how proposed rates align with those of their competitors.
- Validate negotiation positions with credible, external data from sources like Medicare or peer organizations.
- Determine whether you're ready to terminate a payer contract. (Healthcare providers have tripled Medicare Advantage plan terminations in the past three years, according to FTI Consulting, which tracks these movements.)
- Prioritize contract improvements where the greatest disparities exist, focusing efforts where they can have the most impact.

Use these action steps to analyze revenue distribution among payers:

- Extract revenue data from your billing system or EHR for a defined period, segmented by payer.
- Compile totals for each payer, ensuring both fee-for-service and value-based payments are included.
- Calculate the percentage contribution of each payer to your organization's overall revenue.
- Create a ranked list or dashboard highlighting top revenue-contributing payers.
- Review and update this analysis regularly to track changes in payer mix and adjust negotiation priorities accordingly.

You can also depend on payer contract management software to assemble this data with a few keystrokes. Start with revenue cycle reports and examine the data they generate.

Robust contract software can assemble:

- Revenue leakage report
- Charge integrity report

- Denial analysis report.
- Revenue forecast report
- Payer performance scorecard
- A/R aging analysis
- Operating margin report
- Total margin report
- Payer mix analysis
- Workflow analysis report
- Clean claims rate
- First pass yield
- Underpayment detection report
- Contract performance analysis
- Claims status report

These reports help organizations identify revenue risks, optimize billing and claims processes, improve collections, track payer performance, and ensure compliance.

Data that demonstrates your value and strengthens your contract negotiation position

Effectively showcasing your organization's strong performance on quality and patient experience metrics positions you as a preferred provider to payers, making your network participation more valuable. Quality outcomes, high patient satisfaction, and efficient care make a compelling case for higher reimbursement rates and stronger contract terms. This evidence-backed approach gives payers a concrete reason to invest in your continued partnership.

Performance on quality metrics

Use clinical quality/outcomes data and patient satisfaction scores demonstrates the value your organization offers to payers and patients.

It ensures you can:

- Standardize care delivery, ensuring consistent, evidence-based processes across your organization and reducing variation in outcomes.
- Identify operational inefficiencies and target improvement efforts, streamlining workflows and better utilizing resources.
- Foster a culture of accountability and continuous improvement, supporting higher patient satisfaction and better organizational reputation.
- Show payers your ability to serve diverse or high-need populations, or coverage in strategically important locations.
- Leverage data showing your team's advanced certifications, specialties, or subspecialties that may not be readily available elsewhere.

Use these action steps to measure performance on quality metrics:

1. Select relevant clinical quality and patient satisfaction metrics that align with your organization's goals and payer requirements.
2. Extract data from electronic health records (EHR), patient surveys, and other reporting systems.
3. Aggregate and standardize data to ensure consistency and comparability across providers, departments, and locations.
4. Share results with clinical and administrative teams to develop targeted action plans.
5. Showcase total patient volume, referral patterns, geographic reach, and unique or high-demand services offered.

Measuring and acting on quality metrics empowers your organization to consistently deliver high-caliber care while demonstrating its value in payer negotiations.

MD Clarity fuels your power in healthcare contract negotiation

If your practice is not regularly examining and renegotiating contracts with insurers, you are abandoning revenue.

When Becker's Healthcare asked vice president of payer strategy at Ensemble Health Partners, Brad Gerstner, how healthcare organizations can gain more leverage in contract negotiations, he responded:

> **"**The key is data. I often emphasize to my clients that data is their greatest leverage. One of the most important steps is proactively holding payers accountable. The moment a payer fails to meet its contractual KPIs, we flag it immediately — whether through formal demand letters or direct discussions. This approach sets a precedent that every contractual change, even seemingly minor ones, will be scrutinized and challenged if necessary."

Get the data to win fair reimbursements for procedures and better contract terms when you leverage MD Clarity's RevFind contract management software. Use it to gain comprehensive oversight of denials, appeals, contracts, and underpayments. The intuitive dashboards reveal payer contract performance. In other words, it measures underpayment and denial patterns by payer and CPT code, highlighting the financial impact and spotlighting appeal opportunities with the highest likelihood of success. The platform also uncovers frequently

misapplied denial reasons, such as improper claims for timely filing or authorization, and streamlines the appeals process with features for tracking appeal status, labeling accounts, and managing batch work queues, significantly reducing manual effort.

Explore how RevFind can help you improve your stance in healthcare contract negotiation. Schedule a demo today!

Get paid in full by bringing clarity to your revenue cycle

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