REVENUE CYCLE MANAGEMENT

How to Negotiate Reimbursement Rates with Insurance Companies

Suzanne Long Delzio • 20 minute read • May 19, 2025

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For too long, health plans operated with fixed fee schedules, subjecting providers to a "take it or leave it" approach and a dire power imbalance in the business relationship.

Many private insurers peg their fee schedules to Medicare's rates (e.g. paying a percentage of Medicare allowable for each CPT code), so Medicare's cuts tend to feed into commercial contracts. Given that Medicare dropped payments to physicians by 2.93% (the fifth consecutive year of Medicare payment cuts for physicians), payers will want to follow suit.

Healthcare organizations do not have to stand for it.

Because negotiating even small increases for select codes can yield significant revenue gains, negotiating reimbursement rates with insurance companies today is critical.

As Daniel Morrisette, CFO of multi-state, nonprofit Catholic healthcare system CommonSpirit, 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."

Given these pressures, more healthcare organizations have started assertively negotiating for higher reimbursement rates. Tenet Health, HCA Healthcare, and UnitedHealth Services all won higher rates from UnitedHealthcare Group and others.

If you're done passively accepting unfavorable payer rate and term changes, here, you can review how to negotiate better reimbursement rates with insurance companies. Join your peers in calling payers on their bad behavior so that your community can continue getting the care they need.

What are reimbursement rate negotiations?

Reimbursement rate negotiations are the process by which healthcare providers and insurance companies discuss and agree on the amount the insurer will pay for specific medical services and procedures.

These negotiations typically occur when establishing a new contract or renewing an existing one, and involve reviewing fee schedules, claims processes, payment timelines, and other contract terms to ensure fair and sustainable compensation for providers. The goal is to reach mutually beneficial terms that reflect the provider's value, market rates, and operational costs, ultimately supporting the financial health of the provider and the cost of care for patients.

Embrace your power in today's reimbursement rate landscape

Provider reimbursement rates for Medicare physician service have not had an increase in recent years. In fact, rates have been consistently declining.

In the *Becker's* article mentioned above, two healthcare leaders discuss "the battle at the bargaining table".

Of course, money takes center stage.

For providers, margins remain exceptionally tight, and inflation ravages operational costs. For payers, rising medical and cybersecurity costs squeeze margins.

Still, with national insurers like UnitedHealth Group, Anthem, Aetna, Cigna, and Humana routinely reporting profit margins in the 3–6% range, and provider margins typically falling below 3% or even going into negative territory, it's the providers that are experiencing real threats to viability.

With insurance companies refusing to pay feasible reimbursements, more providers are resorting to the nuclear option: plan termination.

USA Today reports that more hospitals and physician groups are terminating contracts with private Medicare Advantage plans due to payment disputes and routine denials. In some states, entire segments of the provider community have boycotted or exited managed care plans due to unsustainable payment rates. This new willingness to walk away has begun improving providers' negotiation stance.

Also behind the new provider empowerment in reimbursement rate negotiation is CMS's 2020 Transparency in Coverage (TiC) ruling, which, although initially intended to benefit patients, now also provides critical competitive information for providers.

Healthcare leaders and even CMS lauded TiC as a way for providers to:

- Gain access to previously confidential competitor and payer pricing data, enabling greater market awareness.
- Perform accurate competitive analysis by benchmarking your rates and services against others in your region.
- Get the data needed to justify requests for higher reimbursement rates or better contract terms during negotiations
- Apply pressure on payers to adjust their rates to reflect clear, data-driven market realities and ensure fair compensation.

This power requires access to reimbursement transparency, a phenomenon backed by federal initiatives, even if inadvertently.

It's happening: Provider power in the contract negotiation process

With these developments, payers are facing newly empowered providers. There is some evidence that payers are starting to learn that they must come closer to providers' requests. If they don't, they risk negative news coverage and declining membership roles.

As reported in *Becker's* article linked above, Ken Steele, partner at ECG Management Consultants, reports,

> "we're seeing more aggressive rate proposals for two- or three-year contracts. Providers are also being more vocal about their value proposition...[and] are pushing harder to highlight these efficiencies and encourage collaboration with payers. Many organizations are now using this data to justify rate increases, demonstrating that they're delivering greater value than what they're being paid for."

The road to your empowered reimbursement rate negotiation stance

We turn again to ESC consultants' Ken Steele to explain,

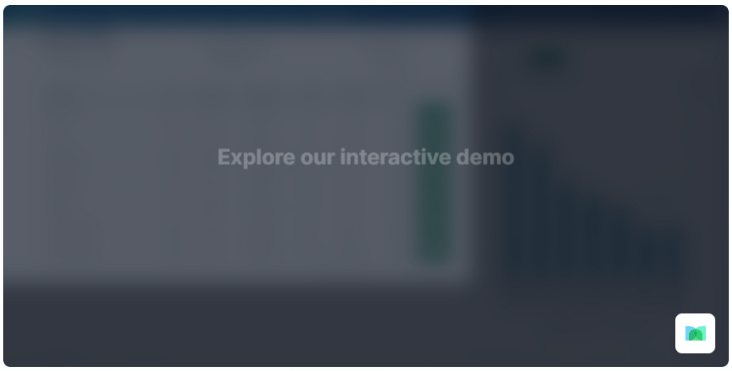
> "Previously, payers asserted during the negotiations that providers were above market rates, but there was little or no data to verify it. Now, with publicly available price transparency data, additional data sources, and analytics tools, hospitals and physician groups can accurately compare their rates to competitors...Robust data analytics are now essential for negotiations with payers."

Without proactive negotiation, providers get locked into rates that do not cover rising operational costs or reflect the true value of their care, leading to financial strain and even jeopardizing the long-term viability of their practices. Negotiating higher reimbursement rates enables providers to reinvest in their practices--whether through hiring skilled staff, adopting new technologies, or expanding patient services.

Publicly available data is most conveniently accessed via contract management software, AI- and automation-driven platforms proficient at:

- Verifying that actual payments align with the terms outlined in your contracts.
- Simulating the financial impact of proposed rate adjustments before agreeing to them.
- Assessing the competitiveness of payer contract terms against industry benchmarks.
- Uncovering revenue shortfalls resulting from underpayments.
- Pinpointing the underlying reasons for revenue leakage to address and prevent future occurrences.
- Evaluating how adjustments in rates could affect your overall revenue
  Leverage benchmarking insights to strengthen your position in contract negotiations.

Take a quick, self-guided tour through a powerful contract performance optimization and management tool:



Common provider obstacles to negotiating reimbursement rate changes

Now that you know that providers are pushing for (and getting) better reimbursements without hesitation, you should consider your own strategy. The first step is to overcome the attitudes typical of the previous period when payers ran the table.

Embarking on reimbursement negotiations with payers starts with calibrating your team's mindset. A proactive, informed, and assertive attitude is crucial for overcoming the inherent challenges and transforming potential roadblocks to higher reimbursements. A positive and prepared approach empowers providers and staff to confidently address obstacles and advocate effectively for fair compensation.

Here we review the obstacles you must overcome at your organization before you even reach out to payers, let alone push them for more. Jump on these solutions to achieve the revenue you deserve.

Perceived conflict and contentiousness

The negotiation process is often viewed as difficult and contentious, deterring some providers from even initiating it.

Solution

Adopt a collaborative mindset, framing negotiations as a business discussion aimed at finding mutually beneficial solutions rather than a confrontation. Prepare thoroughly with data and a clear understanding of your value proposition, allowing you to approach the conversation with confidence and professionalism. Focus on building a partnership rather than winning a battle.

Payer resistance

Insurance companies may resist changes to reimbursement rates due to their own financial constraints, including the rising costs of healthcare delivery. They often have strict guidelines and fee schedules already in place, making it challenging for providers to secure higher rates.

Solution

Present a compelling, data-backed case demonstrating your organization's unique value, efficiency, and positive patient outcomes that can lead to overall cost savings for the payer. Understand their priorities, such as member satisfaction or specific quality metrics, and show how your services align with and support these goals. Be prepared to articulate how market changes and increased operational costs necessitate revised rates.

Data management

Payers respect data-driven insights. You'll have to aggregate and analyze significant amounts of data, including reimbursement data, payer metrics, patient feedback, and clinical outcomes, to build solid rationales for why you need reimbursement improvements. When providers struggle with data overload or misinterpret information, they weaken their negotiating position.

Solution

Invest in data analytics capabilities or partner with experts to effectively collect, analyze, and interpret your key performance indicators and market benchmarks. This may even be a first step before you even consider reimbursement negotiation.

Transform your data into clear, concise, and compelling visualizations that directly support your negotiation points, demonstrating your practice's value and efficiency. Ensure your data accurately reflects your performance and justifies your requested rate adjustments.

Contract complexity

Today's payer contracts are far more complicated than those written just 10 years ago. Payer contracts contain complex legal terminology that can be difficult for providers to interpret. This can lead to misunderstandings about their rights and responsibilities, potentially resulting in unfavorable terms or missed opportunities for better rates.

Solution

If you feel you're not equipped to negotiate contract rates and terms confidently, you're probably right. This sense conveys that it's time to bring in contract specialists, contract software, in-house contract training, and outsourcing contract management. In our recent post RCM Outsourcing: Why Keeping Revenue Cycle In-House is Better, we advocate for keeping contract management in-house to maintain lower expenses, better control, full cost transparency, better scaling opportunities, and lower compliance risks. Come to terms with the time and staff commitment required to actively manage contracts. A skilled, in-house contract specialist using advanced contract management software backed up by a customer success team and engineered to handle complex contracts imparts all the expertise you need.

Payer relationships

A pervasive RCM staff shortage makes it tough for providers to maintain positive relationships with payers. This is especially true in markets where patients have limited insurance options.

Solution

Despite internal staffing challenges, most providers find that investing time in channels with key payer representatives builds rapport and understanding. Leverage technology for efficient interactions where possible, and consistently demonstrate your commitment to quality care and administrative efficiency, which benefits both parties. Share performance highlights that reinforce your value to their network. Our Navigating Payer Relationships blog provides two approaches to effective payer interaction.

Claim denials and underpayments

Ongoing issues with denied claims and underpayments can complicate the negotiation process. These problems need to be addressed alongside rate discussions.

Solution

Proactively address and resolve claim denial and underpayment root causes before negotiations so you can showcase improved billing accuracy and operational efficiency. Present data on your denial management improvements to demonstrate reduced administrative burdens for both your practice and the payer. This strengthens your position as a reliable and efficient partner, making your rate requests more justifiable.

Fear of unfavorable outcomes

Some providers may fear that attempting to negotiate could lead to worse terms or even termination of their contract with a payer.

Solution

Mitigate the fear of negative outcomes by meticulously preparing a data-driven case that irrefutably demonstrates your practice's value, market competitiveness, and the necessity of the proposed rate adjustments. Clearly define your bottom line and be prepared to articulate the non-negotiable aspects of your proposal, while also identifying areas for potential compromise. Confidence derived from solid evidence and a clear strategy significantly reduces the likelihood of unfavorable results.

Steps to negotiate reimbursement rates with insurance companies

As we discuss in our payer contract negotiation article, you can divide payer negotiation into three steps: preparation, negotiation, and tracking.

Step 1: Prepare for payer negotiations

1. **Start early & plan strategically:**

    - Initiate your preparation and open negotiation discussions at least three months ahead of contract expiration dates to allow ample time for thorough review and discussion.
    - Evaluate managed care contract performance and compare each individual payer's performance against that of its peers. Use Medicare's PFS Look-Up Tool as benchmarks for comparison.
    - Clearly define your goals before entering negotiations, outlining what you aim to achieve and identifying areas where you might be willing to compromise.
    - Develop a logical, data-supported, and fiscally reasonable proposal that will be compelling and difficult for the payer to contest.
    - Consider innovative approaches, such as outlining how your practice can help reduce overall expenses for the payer, and then negotiate for a portion of those demonstrated savings to be shared back with your organization.
    - Prioritize which contracts to focus on based on their overall impact on your revenue, considering factors like patient volume under that payer and current reimbursement rates.
    - Create a "comprehensive payer profile" as suggested by HFMA. This involves understanding the payer's contracting goals (which can sometimes be gleaned by reaching out to them in advance), mining your internal claims data for insights, scrutinizing denial trends, and discussing current payer-specific issues with your revenue cycle staff.

2. **Identify High-Impact Codes & Services:**

    - List your top CPT codes--typically, the 20% of codes that generate approximately 80% of your practice revenue.
    - Concentrate your most assertive negotiation efforts on securing the best possible rates for these critical, high-volume, or high-revenue codes.
    - Rank your service lines and individual provider codes by the revenue they generate. This clarity will help you determine where to push hardest for rate improvements and where you might have more flexibility to compromise.
    - Specifically target services characterized by high patient volumes, significant operational costs, or existing, demonstrable reimbursement gaps.
    - Further refine your priorities by ranking payers based on their total contribution to your overall revenue, the severity of any underpayments (e.g., payers with rates >15% below competitors), and the administrative burden they impose (e.g., frequent denials, consistently delayed payments). For instance, a behavioral health clinic identified its top negotiation priority when analysis revealed that a single payer, responsible for 42% of its revenue, was reimbursing at rates 30% below Medicare.

3. **Analyze current payer rates & performance:**

    - Meticulously document the current reimbursement you receive from each payer for your most frequently billed CPT codes.
    - Benchmark these current rates against Medicare's fee schedule as a foundational reference point.
    - Gather comprehensive data on your current payer mix, the prevailing reimbursement rates from each, detailed claim denial rates (noting that a Guidehouse/HFMA survey found 41% of

leaders experience denial rates above 3.1%), and patient utilization patterns under each plan.

- Assemble detailed payer-specific performance metrics, including:
  - Reimbursement trends: Track how reimbursement rates for your key services have evolved over time with each specific payer. This analysis helps pinpoint payers who consistently underpay or lag behind market rate adjustments.
  - Volume per payer: Understand the volume of claims and the total revenue associated with each payer to effectively prioritize your negotiation efforts and identify where rate changes will yield the greatest financial impact.
  - Denial patterns per payer**:** Analyze the reasons for denials and the denial rates specific to each payer. This can uncover systemic issues, such as recurring requests for documentation or unannounced changes in payer policy, which can then be directly addressed during contract discussions.

- Leverage publicly available price transparency data and advanced analytics tools to accurately compare your practice's rates with those of competitors. This data is crucial for justifying requests for rate increases, especially when you can demonstrate that your practice delivers superior value compared to what current payment levels reflect. This transparency diminishes a payer's ability to assert, without evidence, that your rates are "above market".

4. **Create a comparative data repository (e.g., spreadsheet):**

- Develop a robust system, such as a detailed spreadsheet or a dedicated healthcare contract management platform, to compare payer payments side-by-side for each key CPT code. Include data points like service volume, total revenue per payer, and benchmark comparisons to Medicare and competitor rates.
- This clear, visual comparison of rates and terms across payers will effectively highlight discrepancies and help you define precise negotiation targets.
- Ensure all data used is meticulously accurate and directly supports the specific rate adjustments or term modifications you are requesting. Many healthcare organizations are increasingly investing in revenue cycle automation, artificial intelligence (AI), and machine learning capabilities, which can significantly aid in the complex tasks of data compilation, analysis, and modeling for negotiations.

5. **Document key financial data, costs & value proposition:**

- Identify any payer rates that currently fall below Medicare reimbursement levels; the goal should be to have zero instances of this [Previous Text].
- Track the history of rate escalations (or lack thereof) from each payer over the last three years. Aim for consistent, reasonable increases, such as 3-5% every three years, to keep pace with rising costs.
- Know your costs**:** It is essential to understand the true cost of delivering your key services. Conduct detailed service line costing, accounting for both direct and indirect expenses, to clearly demonstrate when current payer rates are insufficient to cover these costs and to negotiate for an adequate operational margin. Benchmark your costs against relevant regional or national standards to further support your position.
- Build your value proposition**:** Quantify your organization's unique value using concrete performance metrics that resonate with payers (see above).
- Understand Medicare Advantage (MA) dynamics: Be acutely aware of the reimbursement landscape for MA plans. Providers often receive payments around 90-95% of traditional Medicare rates from MA plans, even though these plans may receive approximately 102% of Medicare rates from CMS.

Payers might strongly resist rate increases on MA products but may be willing to offer substantial increases on commercial products as a way to "pacify" providers regarding MA concerns, effectively shifting the financial burden.

6. **Prepare Your Presentation & Negotiation Strategy:**

- Use your meticulously compiled data to construct a compelling, evidence-based case for your requested rate adjustments and contract modifications.
- Clearly and concisely **articulate your practice's needs**, specific concerns with current terms, and the well-supported reasons for any requested changes to the contract.
- Present your findings and proposals respectfully but firmly, while also being prepared to engage in good-faith compromise on certain terms where appropriate.
- Maintain a win-win mindset: Approach negotiations with an understanding of the payer's economic goals and business concerns. Look for opportunities to create mutually beneficial solutions that address the needs of both parties.
- Address all contract aspects: Remember that negotiations go beyond just reimbursement

rates. Thoroughly discuss and negotiate terms related to claim submission deadlines, payment turnaround times, prior authorization requirements, appeal processes, and opportunities for administrative streamlining, such as promoting electronic claim submission or simplifying coding requirements.

- Negotiate claim denials proactively**:** Address common reasons for claim denials directly within the contract language. Seek clearer definitions for medical necessity, faster turnaround times for resubmissions, or a reduction in administrative hurdles that lead to denials.
- Prepare for tough stances and potential impasses: Given rising operational costs and historically insufficient rate increases, many providers are now adopting more aggressive negotiation stances, often proposing multi-year contracts (e.g., two or three years) with built-in escalators. You must also be willing to walk away from a contract if the offered terms are financially unsustainable or do not adequately value your services; contract terminations, while a last resort, are reportedly becoming more common in the current environment.
- Cultivate Payer Relationships: Whenever possible, strive to establish and maintain positive, professional working relationships with payer representatives. Strong relationships can open doors to more productive and collaborative conversations, although this can be challenging given the high turnover often seen among payer contracting staff.

Step 2: Negotiate

With thorough preparation complete, you are now equipped to engage payers and advocate for more equitable contract terms.

1. **Initiate and prioritize:**
   - Gather contracts: Ensure you have all current contracts. If missing any, request them from the payer immediately.
   - Analyze existing terms: Scrutinize every line of your current contracts, especially comparing terms to your "best terms" payer as a benchmark.
   - Notify payers: Inform payers of your intent to negotiate approximately 30-60 days before the contract renewal date.
   - Categorize desired changes: Upon receiving any new contract proposals, review them meticulously. Categorize your requested changes into "must-haves," "like-to-haves," and "ideal" to guide your negotiation strategy. Be prepared to stand firm on "must-haves," even if it means potentially walking away.

2. **Develop and present your proposal:**
   - Draft your proposal**:** Clearly articulate your requested changes to terms and rates in a formal proposal letter.
   - Anticipate initial resistance**:** Be prepared for payers to initially say "no" or resist opening discussions. Maintain your resolve.
   - Communicate assertively: Restate your determination to amend contract terms. Focus on facts, avoid emotion, and reference other payers' more favorable terms and rates as leverage. Emphasize that fair reimbursement enables you to provide quality care to your subscribers. Remember, terminating the contract is always an option (unless you're dealing with just one or two payers in your area.)

3. **Justify your requested changes:**
   - Highlight time since last increase: Emphasize the duration since your last rate adjustment, aiming for a standard increase (e.g., 3-5% every three years). Use data from your best-paying contracts to support this.
   - Stress your viability: Explain that fair reimbursement is essential for your practice to remain viable and continue serving patients, which is a shared responsibility with the payer. Reference rising labor, operating, and supply costs, contrasting these with the payer's financial performance if relevant.
   - Demonstrate your unique value: Articulate what makes your practice valuable to their network. This includes:
     - Unique offerings: Highlight services, extended hours, or specialized care (e.g., sole oncologist in the area) that differentiate you from competitors.
     - Community influence: Mention any positive community presence, awards, or media recognition that enhances your practice's (and by extension, their network's) reputation.
     - Alignment with payer goals**:** Research the payer's stated priorities and show how your practice aligns with their vision for quality providers and member satisfaction.

4. **Navigate the negotiation process:**

- Stay Persistent: Don't be deterred by initial refusals. Continue to advocate for your position calmly and factually. As legendary healthcare contract negotiator Doral Jacobson warns, the first answer is always, “no.”
- Seek support if needed: If feeling overwhelmed or if discussions stall, consider engaging an attorney, negotiation coach, or an objective third party for guidance and support.

Step 3: Track payer performance post-negotiation

Securing a new contract is a significant achievement, but the work doesn't end there. Continuous monitoring is crucial to ensure payers adhere to the negotiated terms and that your practice realizes the expected financial benefits. Take these steps to carry out meticulous tracking:

1. **Monitor key performance indicators (KPIs):**
    - Regularly track essential revenue cycle KPIs to assess the impact of the new contract. Key metrics include:
        - Net revenue
        - Accounts receivable (A/R) days
        - Cash flow
        - Claim denial rates and reasons
        - Payment accuracy against contracted rates
        - Compliance with all contract terms (e.g., timely payment, prior authorization processes).
2. **Analyze and compare performance:**
    - Compare your actual financial outcomes against pre-negotiation budgets and forecasts.
    - Identify any variances to pinpoint areas where the new contract is performing as expected, exceeding expectations, or falling short.
    - Drill down into discrepancies to understand root causes (e.g., if expected revenue isn't materializing, is it due to incorrect payment, unexpected denials, or volume changes?).
3. **Communicate findings and take action:**
    - Share your performance analysis with your revenue cycle team and relevant stakeholders.
    - If issues arise (e.g., payer not adhering to new rates, unexpected policy changes impacting claims), promptly engage the payer to address discrepancies and enforce contract terms.
    - Use these ongoing performance insights to inform continuous improvement efforts within your revenue cycle and to prepare for future contract renewal discussions.
4. **Stay vigilant for unilateral changes & renewal tactics (ongoing & pre-renewal):**
    - Maintain awareness**:** Even outside of formal renewal periods, be alert for subtle modifications to payer policies, fee schedules, covered procedures, or payment processes that could impact your negotiated terms. These can sometimes be introduced with limited transparency through updates to provider manuals or online portals.
    - Scrutinize communications**:** Carefully review all communications from payers, paying close attention to any language that might indicate unilateral policy changes or adjustments to reimbursement methodologies.
    - Manage auto-renewal clauses: Be acutely aware of auto-renewal clauses and timelines. Proactively engage payers well before auto-renewal dates to prevent terms from changing without your active review and consent.
    - Prepare for renewal tactics: As the next contract renewal approaches, anticipate that payers may again employ strategies like presenting changes close to deadlines. Revisit your preparation steps to counter these effectively.

MD Clarity guides you through how to negotiate reimbursement rates with insurance companies

Improving reimbursement rates is both a right and a necessity for healthcare providers. Fair compensation ensures providers can maintain financial stability, invest in quality care, and continue serving their communities. By actively managing and negotiating reimbursement, providers protect their ability to deliver essential services, making fair payment not just a business priority but a professional obligation.

MD Clarity helps healthcare organizations improve reimbursement rates by making contract performance and data accessible. Its contract management platform, RevFind, brings the data muscle when you go to negotiate reimbursement rates with insurance companies. Among its functionalities, RevFind

- enables organizations to clearly distinguish between denials and true underpayments, compare reimbursement performance across payers, and identify which contracts deliver the greatest value.
- eliminates manual spreadsheet management and provides actionable, data-rich insights for ongoing rate evaluation and contract performance tracking.
- uses rate modeling tools to help managed care teams accurately project the impact of proposed payer rate adjustments, helping organizations base their reimbursement strategies on concrete data and negotiate from a position of strength.
- simulates various contract scenarios to determine the most advantageous combinations, ensuring that negotiations are guided by real-time benchmarking and market realities.

For providers, standing up to payers' legions of lawyers, data, and strategists takes allies. RevFind works shoulder to shoulder with your organization to combat persistent payers proclivity to shave reimbursements.

Schedule a demo to learn how you can get a clear idea of contract performance, payer value, and proposed rate changes.

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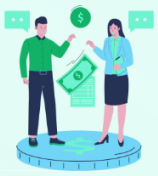

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