Improving payer relationships: Negotiation tips for practice managers

MGMA affiliate members and AdminiServe partners are healthcare industry experts. We asked them to provide insights on how medical practices can improve their relationships with individual insurance carriers to optimize contract negotiations and improve the patient experience. Here are a few of their tips and suggestions:

“When going to the table to negotiate with a payer/network, instead of asking for an increase, tell the rep you are looking to model an offer to renegotiate and that you want to know on what basis to structure the offer so that they can support it. Some examples to suggest are percent or conversion factor of a given year and locality of the Medicare Resource-Based Relative Value Scale (RBRVS), carve-outs of a band of codes or of a handful of highly utilized codes in your practice, or multi-year escalators. Or, ask if there is a pay-for-performance program for which you are eligible.” – Penny Noyes, president, chief executive officer (CEO) and founder, Health Business Navigators, Bowling Green, Ky., p.noyes@HealthBusinessNavigators.com, AdminiServe partner

“Practices should track and measure three financial elements to help keep the playing field level during negotiations – payment and patient history, practice percentage impact and peer comparable payments. Improving your relationship with payers and the patient's experience relies on ongoing transparency and insight into these comparative analytic measurements. Waiting until contract negotiations to review and leverage these data points puts practices at a severe disadvantage.” – John Stanton, vice president of consulting, RemitDATA, Plano, Texas, jstanton@remitdata.com, Corporate affiliate

“Since insurance carriers are required to deliver electronic remittance advice (ERA)/electronic funds transfer (EFT) by 2014, medical practices can strengthen these relationships by connecting to insurance carriers in a private cloud for clearinghouse and EFT transactions. This enables practices to reconcile payments automatically to more easily identify and communicate patient payment responsibility with their patients.” – Bill Marvin, president and CEO, InstaMed, Philadelphia, bill.marvin@instamed.com, Corporate affiliate

“Two simple steps practices can take to improve payer relations are to understand their fee schedules and recognize the most common reasons that claims are denied. This puts practices in a better position to negotiate with payers while allowing them to set patient payment expectations.” – Gene Boerger, vice president of provider product development, Emdeon, Nashville, Tenn., gboerger@emdeon.com, Gold affiliate

“Quality measurement and reporting are fast becoming the norm in medical practices. Regular meetings with payers – to understand, discuss and align quality metrics – will give medical practices an advantage in payer negotiations.” – Tana Goering, MD, chief medical officer, Pulse Systems, Inc., Wichita, Kan., tgoering@pulseinc.com, Gold affiliate

“Put effort and time into building a solid working relationship; your interactions should be honest and respectful. Don’t begin every conversation with what your practice ‘wants.’ Focus on open,
positive communication with the patients’ best interest in mind.” – Cass Schaedig, president, Trellis Healthcare, Littleton, Colo., cass@trellishc.com, AdminiServe partner

“Medical practices with whom we work have optimized their relationships with insurance carriers by consistently keeping track of the specific terms of individual contracts and abiding by them.” – Tim Ogonoski, managing director of physician solutions, Huron Healthcare, Chicago, togonoski@huronconsultinggroup.com, Gold affiliate

“By ensuring that they’re in compliance with insurers’ pre-certification requirements, collecting appropriate copayments, attaching notes when required, billing to correct codes, and understanding rates and coverage levels by plans, medical practices can help streamline processes, which lowers administrative costs for both providers and insurers.” – Tim Ogonoski, managing director of physician solutions, Huron Healthcare, Chicago, togonoski@huronconsultinggroup.com, Gold affiliate

“Going the extra mile to comply with individual insurance carriers is a win-win for patients and medical practices. Patients are very grateful when they know that their physician’s office understands their insurance company’s requirements and is making certain that they are met. This creates a ‘no-surprises’ experience for patients, both in terms of access to care and accurately predicting the cost of their care.” – Tim Ogonoski, managing director of physician solutions, Huron Healthcare, Chicago, togonoski@huronconsultinggroup.com, Gold affiliate

“By looking at their entire cost of doing business, medical groups and insurance carriers can seek to minimize administrative processes, which often put their shared patients in the middle. For example, processes such as pre-authorization timelines and protocols carry business costs for both the medical group and insurance companies. Understanding and quantifying the business costs associated with these steps – and potentially modifying them – can provide additional room for negotiation on reimbursement while streamlining access to care for patients.” – Michael Gladson, managing director of revenue cycle solution, Huron Healthcare, Chicago, mgladson@huronconsultinggroup.com, Gold affiliate

“Medical practices must understand their contracts with carriers, and review claims processing performance on a consistent and frequent basis, addressing issues that prevent claims from paying quickly, and making sure all terms are being met.” – Victor Arnold, managing director of physician solutions, Huron Healthcare, Chicago, varnold@huronconsultinggroup.com, Gold affiliate