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Tips for Managing Provider-Payer Relationships in the New Decade

Bill Banks, Vice President of Managed Care/ Revenue Cycle at St. Elizabeth Healthcare, successfully renegotiated five major paver contracts last year ... and he's still friends with those pavers! Market Matters asked Banks to share his thoughts on contract negotiations and the provider-payer dynamic in the new decade.

MM:

Bill, you worked for a large payer in a former life, and now you work for a large provider, which gives you a unique perspective. What is your impression of the current relationship between healthcare providers and healthcare payers?

Banks: It's my impression that the relationship is better now than it has been in the past. I'd attribute that to several factors. First, there seems to be a better understanding, on both sides, of mutual business needs and what it will take to create a mutually beneficial relationship. Recognition of the symbiotic nature of the payer-provider relationship helps to soothe the inevitable strains.

> Second, there are financial incentives for cooperation. Over the past decade, government payers have generally not kept pace with inflation, to the point where Medicare and Medicaid programs pay providers less than the actual costs to provide care. Providers need commercial payers to make up that shortfall, and generally speaking, the commercial payers have done so. On the payers' side, the inability to sell restricted-network HMOs during the past decade has meant that each payer competes by having the best possible price with the widest possible provider network.

Finally, consolidation on both the payer and provider sides of the industry has meant fewer negotiations need to take place, and that those negotiations are conducted by more experienced and professional people, often by people who have served in both the payer and provider worlds.

MM:

In your opinion what are the top three issues that influence payer-provider contract negotiations and claims adjudication?

Banks: I'll start with the payers:

First, what payers value most is consistency and predictability. They are, after all, insurance companies and must offer a product that depends on the behavior of thousands of providers that they do not control. Payers prefer consistency of claims payments, edits, etc., across a national provider base. This often conflicts with what a provider wants, or has planned on, in a particular region.

Second, payers are like any other buyer of services. When they have market share, they want to use that share to extract deeper discounts from providers: and when they do not have market share, they must buy at a higher price. In order to grow market share, they need to achieve better prices, but they sometimes lack negotiating strength to make that happen. The small payers sometimes believe that providers intentionally disadvantage them to keep them out of the market.





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Finally, payers are obligated to pay for items such as implantable devices that are ordered by a physician. There is no incentive for the hospital, physician or patient to care whether the most costeffective device is being ordered. Payers generally would like the providers to take a more active role in curbing the cost trends associated with these items, but aren't sure how to get that done.

Providers have a different set of issues:

First, providers depend on the commercial payers to pay contracted rates in a timely and efficient manner. Providers have incurred costs to deliver care and then may have to wait significant lengths of time to receive reimbursement. Nationwide, it sometimes appears to providers as if budget (read "staffing") cuts at the payers have resulted in errors and unnecessary delays in programming systems to reflect current contract rates.

Providers would like the commercial insurance industry to adopt one set of coding and care management guidelines and apply those across all payers. Trying to keep track of dozens of payers' various utilization management (UM) programs is very difficult, and doesn't result in any better care for patients. Just as almost all payers now use Medicare's core reimbursement methodology to reimburse for care, providers would like to see the industry adopt a common set of UM guidelines and live by them.

Finally, providers have a very difficult time dealing with self-insured plans handled by third-party administrators (TPAs), accessing the rates of a rental network, but overlaying their own medical management policies, or benefit designs, as well.

MM: What can payers and providers do together to resolve some of these issues?

Banks: Talk early and often about the best way to structure contracts such that we minimize the chances of incorrectly paid claims. More often than not, payers are trying to pay a negotiated contract using a reimbursement system that is not programmed to do what's actually in the document. The result is either a contract that must be manually adjudicated (and that comes with a very high error rate) or a significant delay in implementation of the contract, as negotiated items must be programmed. Neither side benefits when claims are paid incorrectly and then have to be fixed, sometimes by the hundreds or thousands.

MM: In light of some of the issues you see in the industry, tell us about your institution's approach to contract management.

Banks: We start with a statement of our expectations of any third- party contract:

- **A.** We need to achieve a certain margin on our commercial book of business to balance the self-pay and underpaying government payers.
- **B.** Our goal is that all payers pay roughly the same for the same group of services. Thus, our goal in contracting is to keep all payers at the same overall percent of charge, regardless of what reimbursement methodologies they employ or how aggressive their UM/denials process, etc.



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C. Efficient claims processing starts with simpler, standardized contract terms. Whenever possible, we strive for standard reimbursement methods, with a percent of charge contract being the ideal.

This framework is first agreed to internally, so that everyone on the St. Elizabeth's leadership team understands how we go about contracting and how the contracting process will go. We also agree beforehand how negotiations will be conducted and what would trigger such events as a termination of the contract, sending letters to patients regarding a contract termination or even contacting the press about an impending break. That being done, we sit down with our payer partners and outline all of the above and try to come to a consensus about how negotiations will be conducted and what timeframe we'll follow.

I personally am a big advocate of transparency in our dealings with payers, so I will bring exhibits that show all St. Elizabeth's payers (with other payers de-identified) and how they compare on a percent of charge yielded basis. This lets payers know that 1) I'm willing to engage them in the process and 2) I am telling the truth. Payers generally just want parity and to know that I'm not lying to them. If pressed, I would also be willing to have our contracts and models audited to demonstrate parity among payers.

MM: Can you talk about some of the results you've achieved for your organization?

Banks: Without being too specific, we renegotiated five of seven major contracts during the past year, all successfully completed well before any deadline that would have necessitated letters to patients about our outof-network status. Each of the five contracts ended up better than they were in terms of contract simplicity and yield, and put us closer to our goal of essential parity among our commercial payers. Almost as important is that every negotiation was conducted in a friendly manner and ended with a handshake and the knowledge that we can call on these contractors in the future for help

when we need to.

Probably the best example of this was our negotiation with one major national payer. As we were working out contract details, they invited us to their headquarters. My team and I sat down with their contract load staff and went through every line of the reimbursement terms in our contract. At every step, they were able to show us how the words on the page were translated into programming in their system. We were able to discuss best practices, and they were very willing to offer advice on the best way to structure the contract so that human interventions (and thus errors) were minimized. Spending this kind of time up front eliminates hours of error correction on the back end.





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MM: If you could offer one piece of advice

to your former colleagues in the payer

world, what would it be?

Banks: Providers are not the enemy – with a few

well-documented exceptions, they are not out to cheat the payers or cost you money. The best advice I can give to any payer is to take your key providers out to breakfast or lunch once a month without a specific agenda. Just talk about current events at the hospital/payer and the community in general. The more you understand about each other's business, the better able you will be to work around inevitable conflicts as colleagues, versus adversaries.

MM: Any advice for your fellow providers?

Banks: The same advice: Get to know your payer

representatives. They are basically okay people, and much more likely to work on your behalf if you are not strangers.

MM: Thank you, Bill Banks!

Bill Banks is Vice President of Managed Care/Revenue Cycle for St. Elizabeth Healthcare, a six-hospital system with an extensive outpatient network in the greater Cincinnati area. Banks was formerly Vice President, Network Operations, for Humana of Ohio. Humana is one of the nation's largest publicly traded health and supplemental benefits companies.

