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Solid Negotiation Skills Have an Impact on Health Plan Terms

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A clear sense of current market trends, cost of care, and demonstrated efficiencies that reduce cost are essential elements of contract negotiation preparations.

Negotiation leverage, in terms of hospital control, comes from several sources. The most recognized driver is market power based on geographical area or demographic factors. However, hospital/payer relationships, service offerings needed in the community, and negotiation skill and/or negotiation philosophy are other important drivers.

Over the last five years, the United States is estimated to have spent more than $900 billion on hospital care in each year, of which more than $300 billion is paid by private health plans. The Centers for Medicare and Medicaid Services (CMS) estimate that through 2023, hospital care spending will continue to increase almost six percent each year (National Health Expenditure Data, Centers for Medicare & Medicaid Services, Vol. 2017).

Most U.S. hospitals use commercial health plan payments to offset losses from governmental payers and uninsured patients.

Negotiated health plan amounts are complicated and complex. Even if the provider demonstrates efficient operations, net revenue is at stake without properly negotiated payer contracts.

With so much at stake, hospitals and health systems should consider the following questions:

- Can human proficiency, ability, and interaction during negotiations have a greater influence than geographical location and hospital market power?
- If hospitals are in the same market, can competing hospitals achieve the levels necessary to survive without skilled negotiators?
- Are negotiation skill, style, and philosophy strong drivers in achieving desired payment rates during contract negotiation encounters?

A Comparison of Two Hospitals

Examining two hospitals in the same market can help providers understand differences in market position and overall favorability of payment terms. The comparison of relative

market position and payer mix involves data sources from audited financial statements and survey forms, publicly filed Medicare Cost Reports, or publicly filed data for Medicare inpatient and outpatient claims.

For market share, Hospital A controls almost 59 percent of the market where Hospital B about 33 percent. Hospital A has lower percent levels of Medicaid charges and lower percent levels of uncompensated care. Hospital A shows a higher percent of non-governmental payers at 35 percent, whereas, Hospital B is 31 percent non-governmental. The comparison indicates Hospital A has a superior market position over Hospital B. However, while other factors indicate Hospital A appears to have more market power, Hospital A has a lower Net Patient Revenue per Equivalent Discharge™, which suggests Hospital A has lower levels of commercial health plan payments (see the exhibit below).

After examination, the comparison represents considerable base term differences where the methodology is the same. However, on the surface for inpatient terms, the figures alone without investigation could be misjudged. While the MS-DRG base rate appears more favorable for Hospital A with a base rate of almost 32 percent higher, a key term to consider is the outlier/stop-loss provision. Notice Hospital A includes a much higher threshold at almost 50 percent higher, and once met, a lower percent of billed charges paid. With both hospitals reporting high charge structures, the inpatient terms for Hospital B may be more favorable.

On the outpatient side, where methodology is the same, Hospital B appears to have more favorable terms with a higher percent of charges paid for emergency department and all other outpatient services. Where methodology differs (i.e., fixed rate versus variable rate) in outpatient surgery, current charge practices and utilization data would be required to determine payment differences.

While Hospital A has greater market share, Hospital B shows negotiations produced more favorable terms from the major health plan. Such comparisons indicate negotiation skills, style, and philosophy may represent controlling drivers. So how can hospitals use these human factors to aid in developing contracts with the most favorable terms for the hospital?

Comparison of Terms of the Same Major Payer for Hospital A and Hospital B

Facility		Hospital A	Hospital B
Payer		Major Health plan	Major Health Plan
Effective Date		Jan. 1, 2018	Jan. 1, 2018
INPATIENT SERVICES	**General**		
	MS-DRG base rate	$26,372	$20,016
	Inpatient threshold	Total charges > $268,194	Total charges > $178,643
	1st dollar	51.82%	57.93%
OUTPATIENT SERVICES	**Outpatient surgery**		
	Multiple procedure discount		1st = 100%, 2nd and beyond = 50%
	Outpatient surgery (% billing charges)	40.53%	
	Outpatient surgery group 1-case rate		$1,284.29
	Outpatient surgery group 2-case rate		$1,724.73
	Outpatient surgery group 3-case rate		$1,971.71
	Outpatient surgery group 4-case rate		$2,432.73
	Outpatient surgery group 5-case rate		$2,774.39
	Outpatient surgery group 6-case rate		$3,231.30
	Outpatient surgery group 7-case rate		$3,848.74
	Outpatient surgery group 8-case rate		$3,799.34
	Outpatient surgery group 9-case rate		$13,583.79
	Outpatient surgery ungroupable (% billed charges)	40.53%	53.65%
	Emergency Department		
	Emergency department (% billed charges)	51.15%	53.65%
	Other		
	All other outpatient (% billed charges)	44.39%	53.65%

Source: Cleverley + Associates, 2018, Used with permission.

Negotiation Skills for Healthcare Professionals

Negotiation involves reaching an agreement on payment terms through discussion and compromise. Negotiation skills require communicating an engaging vision, advocating services, and convincing others to align efforts and support the common objective (Fernandez, C. S. P., and Roberts, D., "Strengthening Negotiation Skills, Part I." *Journal of Public Health Management and Practice, 21*(2), 214–216).

Several strategies impact negotiations. Prior to the actual negotiating stage is a

period of influence. The period of influence includes five major sources of power: knowledge, attitude, authority, objectivity, and negotiation skills (Fernandez, C. S. P., and Roberts, D., "Strengthening Negotiation Skills, Part II." *Journal of Public Health Management and Practice, 21*(3), 304–307).

Knowledge. Knowledge involves two separate elements; insight data and an individual's technical knowledge reserve. Insight data includes understanding the provider's payer mix, pinpointing costs of providing each procedure potentially negotiated, knowing the provider competition, and using market intelligence (Rizzo, E., "Best Tips on Negotiating With Payers: Administrators Speak Up," *Becker's Healthcare: ASC Review*, 1–8).

Market intelligence requires researching other similar providers' operational statistics to understand internal strengths and barriers to success (Boyd, D., & Finman, L., Managed care: mastering the moving parts. hfm, Healthcare Financial Management Association, May 2010). A healthcare professional individual's technical reserve of knowledge is heightened through the skill of asking questions. Being prepared to ask questions during negotiations is a critical element in gathering information.

Attitude. Attitude refers to strength and relevance of the need and value of the solution (Fernandez and Roberts, Part II).

Authority. Authority can influence negotiations from authority perspectives such as title or higher management level. Authority can also influence negotiations from a positive perceived perspective by knowledge or expertise, by connections and relationships, or as a result of soft skills and emotional intelligence (Fernandez and Roberts, Part II).

Objectivity. Using benchmarking data, planning alternative solutions, and formulating a compelling argument to the terms to be negotiated all lead to objectivity.

Negotiation skills. The knowledge, attitude, authority, and objectivity strategies lead to skill. Skills are based on knowledge gathered, attitude presented, authority exercised, and exhibited objectivity.

Negotiation Styles

In addition to developing negotiation skills contracting professionals must also understand negotiation styles.

Negotiation style categories involve accommodating, avoiding, collaborating, competing, and compromising (Terra, S. M., and Zimmerling, J., "Contracts and Contracting: A Primer," *Professional Case Management, 2016,21*(5), 243–249). These categories can overlap to produce the best approach in negotiation. The style depends on those involved from both parties in the negotiation.

Negotiation Philosophy

Negotiation philosophy complements negotiation skills and style. It refers to the method by which healthcare professionals approach driven interaction with payers in determining payment terms. Often, negotiation philosophy is represented by two distinct approaches; reactive and proactive.

Reactive. A reactive philosophy is essentially accepting terms without intervention. Providers are sometimes given contracts by health plans with "take it or leave it" tactics and then need to prepare operations, reacting to the effects (Kurunthottical, R., "Strategies for Proactive Payer Contract Negotiations," *Medical Economics, 2015 92*(1), 24–25). Accepting terms as presented by health plans is often the result of providers perceiving little to no negotiation leverage.

Proactive negotiation. Proactive negotiation involves several activities to prepare providers for the negotiation stage to determine payment terms. Collecting, analyzing, and having a thorough understanding of the following data prior to coming to the negotiation table can make a significant difference in negotiated terms.

> A clear sense of current market trends
> Hospital cost to deliver quality care
> Business principles

Understanding 5 Negotiation Styles

Healthcare contracting staff can approach health plan discussions with more confidence and knowledge if they understand five typical negotiating styles and when to use them. Certain negotiations may require using overlapping styles to produce positive results.

Accommodating (I lose-you win). The focus of this style is to preserve relationships. It should be used when you are at fault, your position is weak, or you are unprepared. Make sure you know the consequences of conceding before you do so.

Avoiding (I lose-you lose). Use this style when the issue being negotiated is trivial or when the value of resolving the conflict outweighs the benefit. Set expectations by both parties when using this negotiation style.

Collaborating (I win-you win). This should be the primary negotiation style. It requires understanding the other party's point of view and motivations. Note that this style requires more time and may not work with competitive negotiators.

Competing (I win-you lose). This style often is used when relationships are not critical and one you need to get action quickly. During negotiations, use clear language (e.g., "we must have") rather than weaker language (e.g., "we would like").

Compromising (I lose/win some-you lose/win some). In this negotiation style, both parties value fair and equal resolution. Both parties can get fast results but it's also possible to concede to certain terms too early without regard for all aspects of the negotiation.

Source: "Contracts and Contracting: A Primer," Professional Case Management, 2016.

- Demonstrated efficiencies that reduce cost (Kurunthottical, 2015).
- Aggregated service line data
- Case-mix
- Population demographics
- Treatment preferences
- Utilization data

Being proactive and coming to meetings with this data in hand provides leverage for hospitals to secure the best financial outcome for the healthcare provider (Terra & Zimmerling, 2016).

To obtain most favorable contract rates, the proactive negotiation philosophy complements professional skill and style. Proactive contracting involves establishing several payment terms:

- Ensure prompt payment and penalties for lack of compliance
- Eliminate retroactive denials
- Address precluding language of reducing inpatient stays from higher to lower paying service categories
- Establish a reasonable appeal process
- Define clean claims
- Remove most favored nation clauses
- Prohibit silent PPO arrangements
- Include terms for outliers or technology-driven cost increases
- Establish ability to recover payment after termination
- Remove unclear language
- Preserve the ability to be paid for service when patient consent is granted (Cleverley, W.O., and Cleverley, J.O., *Essentials of Health Care Finance. Eighth Edition*, Jones & Bartlett Learning, 2018.)

Engaging in single year contracts or year-to-year versus two to three year with automatic renewals is also another recommended proactive approach.

Recommendations

Hospital profits are based on negotiated payment terms. Negotiators with substantial amounts of market intelligence and skill can achieve favorable outcomes with contract terms. Execution of market intelligence, such as benchmarking terms and utilization data, along with integration of creative thinking and applying negotiation skills can be powerful. However, an initial critical step in knowledge includes understanding the current value of existing contracts.

For example, hospitals should assess if current payment terms cover the cost of service delivery, what or if variation exists in health plan payment plans, and whether hospital peers have better payment arrangements. With the information gathered, hospitals can strategize different scenarios along with understanding the impact of each. After health plan meetings, providers should plan how to execute the knowledge gained with the payer and determine minimal, target, and optimal payment term goals.

By instituting the philosophy, style, and skills best suited for the negotiation situation and payer, healthcare providers can step closer to obtaining the levels of payment necessary to survive. •

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