



Negotiating Non-Rate Terms in Commercial Contracts

Prepared for:

HFMA Arkansas Chapter – 2026 Spring Conference

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Presented by:

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Introductions



Bob Paskowski, CPA
Healthcare Consulting Principal
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Bob specializes in managed care strategy and reimbursement. He uses his “Big Four” audit background and nearly 30 years in payer operations with provider-sponsored health plans and large managed care organizations to serve clients.

Bob helps many health systems and larger provider groups navigate their managed care strategy, including managed care contracting and reimbursement analysis.

Bob also supports healthcare organizations to resolve provider/payer legal disputes, including serving as an expert witness.






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Agenda

- 1. Introduction and Background**
- 2. Top Negotiating Strategies and Tactics**
- 3. Key Contract Terms – Payer Motivation v. Provider Motivation**
 - Administrative Guidelines, Protocols, Reimbursement Policies, and Provider Manuals
 - Amendments
 - Appeals and Reconsiderations
 - Claims Audits – DRG Downgrades
 - Claims Adjustments – Overpayments and Underpayments
 - Medical Necessity
 - Prior Authorizations
- 4. Recent Payer Announcements and Activities**
- 5. What Can Providers Do?**
- 6. Open Discussion – Q&A**

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Introduction and Background

-  Non-rate contract terms relate to real \$\$\$
-  Can be “at the center” of an arbitration case
-  National spotlight on many of these topics
-  Most contracts are on payer “paper”
-  Consider legal review of contracts

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Top Negotiating Strategies and Tactics

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Top Negotiating Strategies and Tactics

1.

Evaluate current relationship

- How to characterize as it relates to other payers
- Frequency of communications
- Relationship of payer and the competitors

2.

Summarize current state (existing contract)

- Identify the prevailing issues
- Review key contract provisions
- Timing on when the last negotiation occurred

3.

Define payer reliance and risk

- Importance of payer participation as it relates to overall strategy and objectives
- Impact on payer if provider is out of network

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Top Negotiating Strategies and Tactics (cont.)



4.
Alternatives to network participation

- OON – higher rates v lower volume (higher patient responsibility) and less dependable claims processing
- Repricing and other single case agreements
- No Surprises Act (IDR)

5.
Document value proposition

- List the value in the areas of access, quality, and affordability
- Understand timing and urgency

6.
Conduct data and analytics study

- How do rates compare across payers and the competitors
- Analyze contract performance versus expectations

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Top Negotiating Strategies and Tactics (cont.)



7.
Identify other reimbursement opportunities (beyond FFS)

- Evaluate risk and investments in value-based programs
- Consider pay-for-performance to full risk options

8.
Ensure that Agreement does not change

- Require that all amendments must be bilateral and in writing
- Limit payer's unilateral right to amend Agreement to conform with changes in the law

9.
Plan for potential expansion of providers covered by Agreement

- Review change of control provisions
- Review assignment language
- Limit time period in which payer can choose what rates to pay

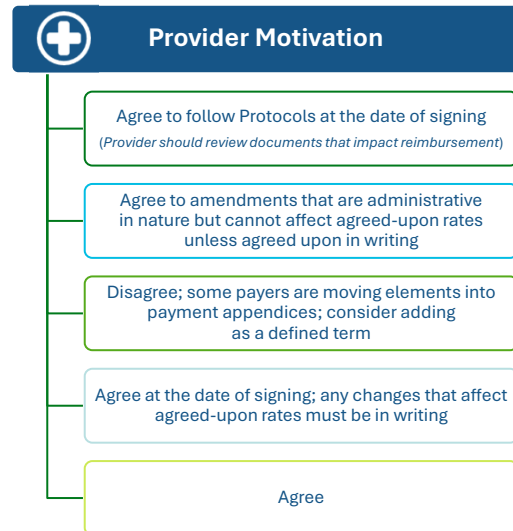
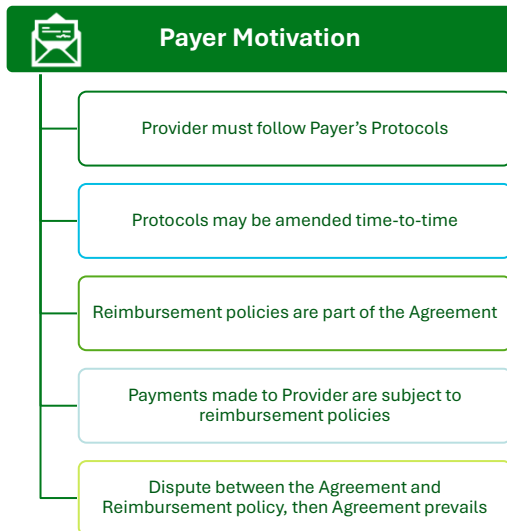
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Key Contract Terms

Payer Motivation v. Provider Motivation

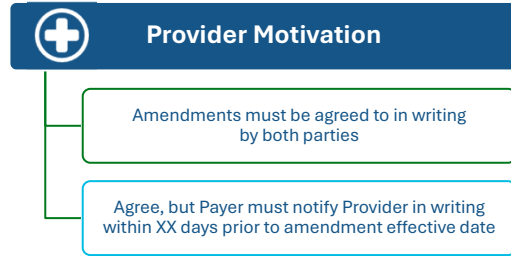
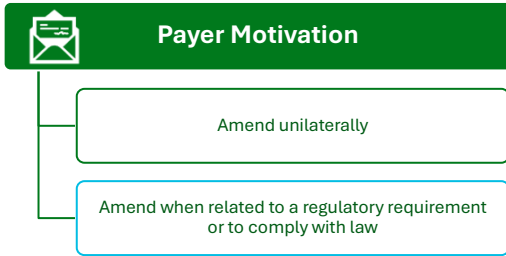
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Administrative Guidelines, Reimbursement Policies, Provider Manual (Protocols)



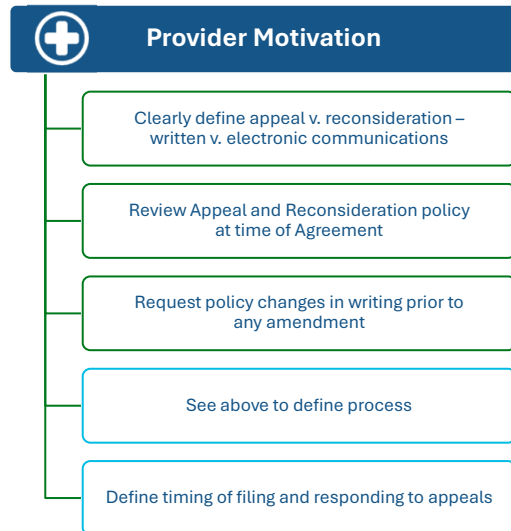
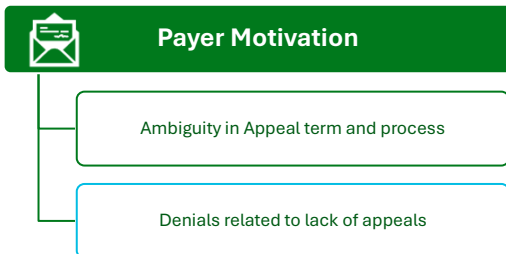
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Amendments



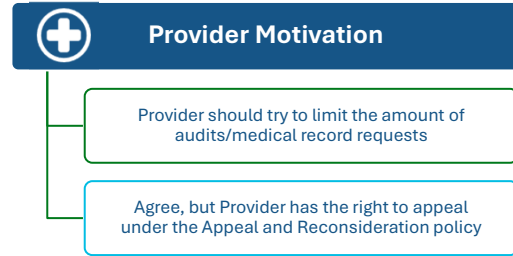
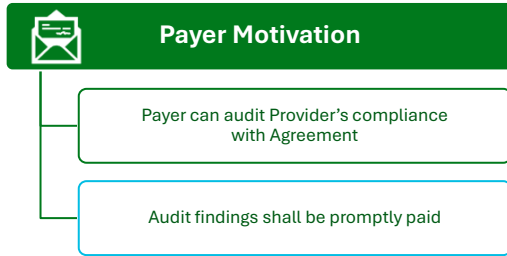
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Appeals and Reconsideration



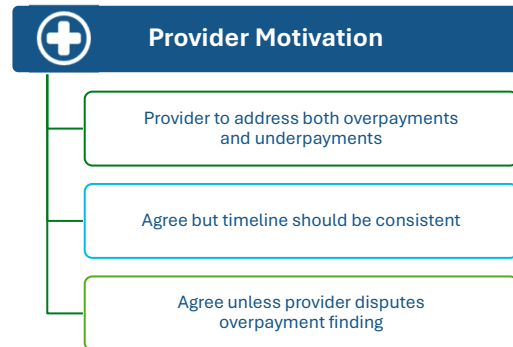
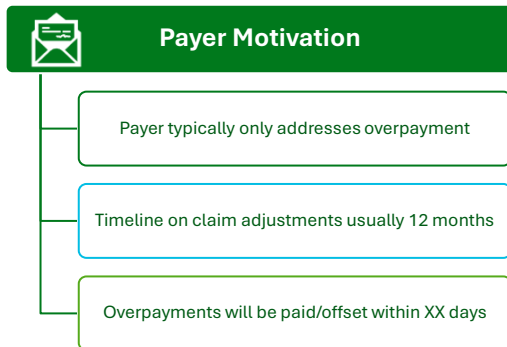
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Claims Audits – Downgrading



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Claims Adjustments – Overpayments and Underpayments



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Medical Necessity



Payer Motivation

Payer defines their view of medical necessity

Provider Motivation

Provider should use definition generally accepted in the industry; avoid Payer having unilateral determination of medical necessity

Provider should include as a defined term in the Definitions section

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Prior Authorizations (PA)



Payer Motivation

Payers create the PA list requirements to be exhaustive

Payer determines timelines to their favor in the PA process

Payer authorization accepted but ambiguous on what is authorized

Payer does not authorize the request

Provider Motivation

Provider should clearly define which services need a PA versus notification only; Provider should seek "gold carding" when appropriate

Provider should agree to a reasonable timeframe to request the PA without compromising timely patient care; similarly request a reasonable response time as it relates Payer response or automatic approval

Provider should define that service is not subject to medical necessity or site of service protocols

Provider should clearly obtain reason for denial and consider as part of a subsequent appeal

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Recent Payer Announcements and Activities

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Recent Payer Announcements and Activities

*2027 Medicare
Advantage rate
announcement*

*2018 – 2024
Risk Adjustment
Data Validation
(RADV) audits*

*Payer states
that provider
needs to deliver
a denial notice
to the patient.*

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What Can Providers Do?

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What Can Providers Do?

- 1. Establish Joint Operating Committees to address high-impact, systemic issues**
- 2. Medicare Advantage claim issues**
 - New online complaint tool to capture basic information about the complainant, beneficiary, provider, and Medicare Advantage plan, a complaint summary, and optional fields for date(s) of service and claim number
 - Provider complaints will be placed into a queue in the CTM, where CMS will review and triage prior to assigning a contract number
 - Available at <https://www.cms.gov/medicare/health-drug-plans/provider-complaints-form>
- 3. File complaints with Department of Insurance**
- 4. Exhaust appeal and reconsideration rights**
- 5. Engage with legal counsel**
- 6. File arbitration demand**

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Open Discussion
Q&A



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Thank you!



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