Payer Strategy Playbook

Reducing friction to restore focus: 8 key strategies

How leveling the playing field with payers can elevate the patient experience

ENSEMBLE™

The cost of payer-provider friction is too high.

It's time for a new approach.

70% of Americans think the healthcare system is broken. It's not chronic conditions that worry them the most, but the high costs and limited access to care.

Constant friction between payers and providers makes these issues worse, and patients ultimately pay the price. Patient frustrations have increased along with denials, and patients have been more proactive in sharing their perspectives on social media.

It’s time to do better. As Medicare Advantage penetration increases and AI-driven denials become more prevalent, providers must shift from reactive problem-solving to proactive payer strategy.

8 strategies to reduce friction and bring patient care back into focus

1. Close contract loopholes.
2. Demand adequate rates.
3. Be the squeaky wheel.
4. Appeal denials with precision.
5. Eliminate errors.
6. Find strength in numbers.
7. Benchmark performance to stay ahead.
8. Communicate to support negotations.

STRATEGY ONE

Close contract loopholes.

Stop giving payers the upper hand. Don’t accept standard or unclear language that enables payers to delay payments or pile on administrative burden. Instead, revise contracts to include language that clearly defines dispute resolution requirements, non-compliance penalties and enforcement mechanisms.

6 key terms to incorporate in your next negotiation

01 Payer shall pay, deny or dispute a clean claim within 30 business days of receipt or pay interest.

02 If Payer fails to dispute all or a portion of a claim within the 30-day period, it may not place the claim into pre-payment review.

03 Payer shall not recoup payment without appropriate notice nor if Provider has requested reconsideration, submitted an appeal or escalated a dispute.

04 No level of care audits shall be performed for inpatient claims where Payer conducted a concurrent review.

05 Payer shall not retroactively deny a claim if Provider obtained a pre-certification or authorization.

06 "Lesser of" language shall not be applied if the resulting reimbursement is not cost neutral or consistent with the intent of the overall reimbursement agreement.

STRATEGY TWO

Demand adequate rates.

The same timeframe that saw provider expenses increase by 18% only saw an effective commercial rate increase of 1%–3%. Since payers have historically been reluctant to agree to adequate rate increases, make a data-driven argument and prepare a strategy in the event an agreement can't be reached.

Payer Strategy in Practice

We worked with a large health system to renegotiate their contract with a major payer and secure long-term accountability, by implementing an out-of-network strategy with a patient ombudsman program and PR campaign to educate the community on care access. On the planned termination date, **the payer conceded to a 20% rate increase and contract language to protect against future payment delays**.

4 critical steps for achieving adequate rates

Set the right tone

Everyone should be working with the patient's best interest in mind. Ensure both payers and stakeholders understand commonsense rate increases enable you to continue to serve your community, including those who can't afford care.

Overprepare

Start planning a year ahead of your next negotiation and create a robust project plan. Engage stakeholders across managed care, clinical operations, government relations, communications, finance, legal and compliance. Prepare for external dialogue and proactive communications.

Analyze parity

Access to payer data lets you benchmark volume and rates to compare payer performance. Factor in rate erosion caused by denials and delays — despite contracting for > 100% of Medicare rates, Medicare Advantage plans often effectively pay < 90% of Medicare when denial rates and aged AR are included.

Stay the course

Payers often do not start negotiating until near termination, so be prepared for a drawn-out effort. Prepare an out-of-network strategy in case the payer is unwilling to concede.

STRATEGY THREE

Be the squeaky wheel.

Methodical persistence is key when it comes to pushing back on non-compliant payers. As one health system executive put it, “Unfortunately, payers only respond to two things: termination and litigation. So those are the tactics. And we’ve got to be very diligent.”

2 proven ways to make your voice heard

Issue demand letters

Establish a robust mechanism to review payments, flag issues and automate disputes. Setting up a system to issue batch or individual demand letters can compel payers to resolve disputes while also documenting your proactive efforts for potential litigation.

Exhaust administrative processes

Log all disputes and demand letters sent to payers to track patterns and escalate issues. This systematic approach ensures payers are held accountable and helps you build a strong case for future negotiations.

STRATEGY FOUR

Appeal denials with authority + precision.

Don’t let denials go unchallenged. Payers count on administrative overwhelm to reduce provider reimbursements — but with the right processes and tools in place, it doesn’t have to.

2 steps to accurately appeal denials

STEP

01

Leverage peer-to-peer reviews as the first line of defense. Push back against payer contracts that only allow the treating doctor to do peer-to-peer reviews — they should be focused on delivering care, not defending it.

Instead, ensure a physician advisor well-versed in clinical criteria and payer requirements is allowed to conduct peer-to-peer reviews.

STEP

02

Use AI to make appeals more efficient — at scale. Generative AI isn't just a tool for managing payer behavior — it's a tool for predicting it. We're integrating AI into contract benchmarking, predictive modeling and automated dispute workflows to help providers anticipate and respond to payer tactics before they impact revenue.

Advanced solutions can even integrate with your EHR and use external data — like coverage criteria and payer policies — to automate complex clinical appeals. In this way, your valuable resources can focus on validation instead of manually drafting arguments.

AI in action

Don't underestimate the investment required to make AI work.

Until payers standardize policies, the complexity of building accurate models that can accommodate each payer and clinical condition is not realistic at the scale of one hospital or health system.

By synthesizing and analyzing disparate data sources, including EMRs, clinical guidelines, payer criteria and peer-to-peer recordings we're creating compelling clinical arguments at scale, designed to pass the most rigorous payer scrutiny.

STRATEGY FIVE

Eliminate errors.

Don’t let mistakes drain resources or revenue. Implement fail-safes to avoid common errors that cause unnecessary denials.

Payer Strategy in Practice

We helped a seven-hospital community health system **reduce first-pass denials by 43%** by establishing robust denial reporting and a prevention program, including staff training, root cause analysis and process improvement.

FRONT

Ask payers to outline their own processes for using third-party authorizers so your teams can appropriately manage the requirements and prevent unnecessary denials.

Train front-end teams on the financial impact denials and claims resubmissions have on the organization so they understand the importance of their roles. Emphasize the amount of rework their efforts will decrease by preventing denials from occurring in the first place.

MIDDLE

Automate coding and charge audit for all accounts to ensure accurate reimbursement for services provided.

Accurately and thoroughly document the right information to support patient status, procedures and diagnoses.

Add prompts to your EHR to document clinical decision-making (e.g., Will this patient be admitted? If not, will the patient's length of stay exceed two midnights? If so, why?)

BACK

Stay ahead of the 100+ payer policy changes issued daily. Make sure you're tracking them and adjusting processes to remain compliant.

Form a denials prevention committee capable of analyzing denial trends, sharing results with various stakeholders — including clinical departments — and holding parties accountable for upstream issue resolution.

AI in action

Go beyond sample audits and human reviews.

At Ensemble, we analyze all accounts automatically before they're billed.

Natural language processing extracts relevant information from clinical notes and documentation, then ML models analyze 80,000+ data points to flag potential errors.

Accounts are then shortlisted and prioritized based on probability of errors for operator work queues. This approach prevented $80 million in lost revenue for our clients in 12 months.

STRATEGY SIX

Find strength in numbers.

Don’t go it alone. Peer organizations and proven RCM experts can support your team in reducing friction with payers, and certain payers may even prove to be an unexpected ally — with the right terms in place. Work together with the patient in mind; a more seamless process will benefit all parties.

Payer Strategy in Practice

We helped a 20-hospital system **reduce authorization turnaround time from 3 days to 1 hour** by collaborating with a major payer to leverage Epic’s electronic medical prior authorization capability.

Peers

Amplify your voice publicly with the help of community groups and organizations, which can help tell your story.

Keep these lines of communication open by:

- Aligning with local and national hospital associations to educate the public on the administrative burden providers face
- Keeping local policymakers and large employer groups informed on issues

Payers

Equitable data exchange could be the key to finding common ground with payers — don't give it away for free.

Establish a strategically aligned agreement with cooperative payers to improve revenue cycle outcomes, one that allows you to:

- Automate the authorization request process
- Reduce or eliminate requests for information
- Accelerate payments through streamlined claim adjudication

Partners

Selecting the right RCM partner is critical. Strategic alignment with a proven expert can speed revenue cycle processes and make them much more effective than any one organization could achieve alone.

Your chosen partner should:

- Coordinate with payers, using its scale and connections to amplify your organization's own efforts
- Help drive top-line revenue improvement in addition to cost efficiencies

STRATEGY SEVEN

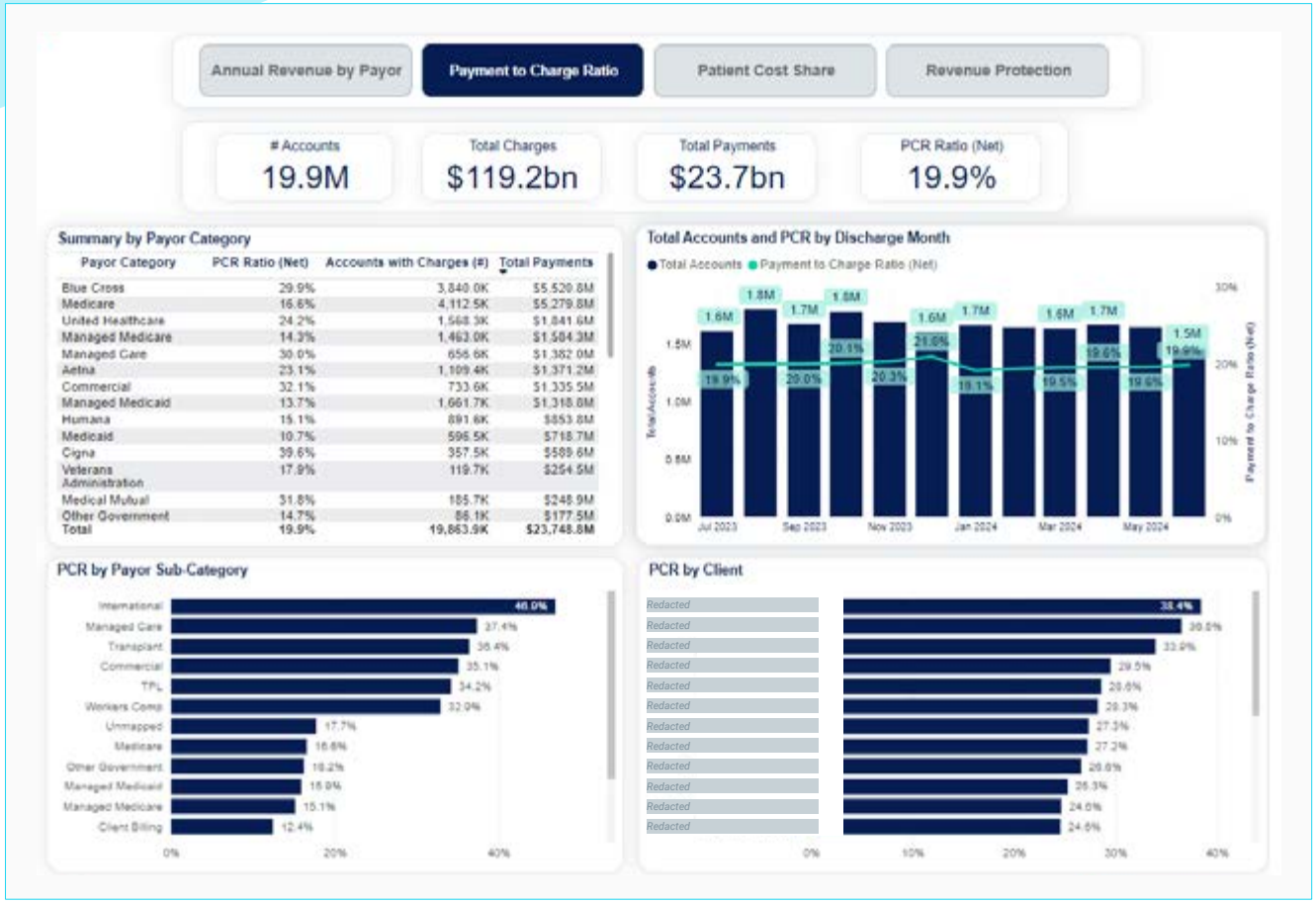
Benchmark performance to stay ahead.

It's crucial to collect, aggregate and normalize data across all your payers to visualize and review a specific payer's performance and compare one payer to all others. Create a payer scorecard that shows top-level insights and lets you drill down into specific payers and categories to identify issues and areas that require quick resolution.

In their words

"The whole revenue cycle background has become a big focus for us. Our last three negotiations have been driven not just by rate, but by whether the payer is a good partner. Can they process claims? Are they creating problems for us? That's been a major issue for us in negotiations, and it's provided us some good leverage to be able to go back and point those things out." — STEPHEN FORNEY, CFO, COVENANT HEALTH

Ensemble's payer scorecard



We normalize data across thousands of payer plans to provide an apples-to-apples comparison of payer performance from the national level down to the account level to identify trends and opportunities for improvement across each of our clients.

Sample KPIs to track

- Clean claims rates
- Payments as a percent of charges
- Payment speed
- Denial rates and reasons
- Appeal volumes and success rates
- Underpayments
- YoY changes in net reimbursements

STRATEGY EIGHT

Communicate to support the negotiation outcome.

Don’t underestimate the power of strategic communications to make an impact during contract negotiations. Make your concerns heard with targeted outreach to key stakeholder audiences — including employers, brokers, policymakers, patients and the media.

4 tactics to take your position public

01

Combine payer performance data with anecdotes to educate your board and policymakers on the financial and community impact of bad payer behavior and inequitable policies.

02

Leverage the power of social media to compel state and federal representatives to visit your facilities and hear about the issues firsthand. Consider highlighting patient stories.

03

Brief local employer and broker groups about payer performance issues and the financial pressures hospitals face, to strengthen their own negotiating power for self-funded employee health plans.

04

Lean on the data by showing individual payer denial rates, the financial impact of those denials for your healthcare organization and the time your providers have spent adjudicating denials when they could have been providing patient care. These small details can have an outsized impact on the public narrative.

Payers aren't going to change **unless providers push them to do so.**

Ensemble has helped health systems recover millions in lost revenue, secure better contracts and reduce denials at scale. The next step is ensuring these wins translate into lasting industry change.

Ready to take action? We're ready to help.

Contact us today / EnsembleHP.com/contact

Ensemble, ranked the #1 revenue cycle managed services company for healthcare organizations, combines certified operators and AI to sustain excellent RCM performance.

ENSEMBLE™