Ovation Healthcare™

Bridging the Divide

Strengthening Provider Relations in Managed Care

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Wanda Wright
VP, Payer Relations

wwright@ovationhc.com

Today's Presenter

Wanda has over 30 years of experience in a healthcare environment, with expertise in Managed Care contracting. She has extensive experience from both the provider and payer settings and has proficiency in all payment models including capitation, fee for service, Exchange Products, Government based products, and Quality Incentive/Fee for Value Programs. Wanda has a successful record designing and implementing effective managed care strategies and advising health systems through negotiations resulting in improved contract administration and yields. Her experience also includes negotiating contracts with hospital and physicians for nationwide insurance companies.

Prior to joining Ovation Healthcare, Wanda dedicated several years as a Consultant and over ten years in contracting specialist and portfolio manager roles for a large health system and an academic medical center. Before transitioning into the provider setting, Wanda worked for several major insurance companies where her responsibilities included recruiting, educating, and maintaining networks of over 1,000 physicians, hospitals, and ancillary providers.

Agenda

- Learning Objectives
- Primary Drivers of Fiction and Why They’re Important
- Administrative Burden and Contract Performance
- Collaborative Communication & Relationships
- Strengthening Payer Relationships
- Data Transparency, Validation & Normalization

Learning Objectives

- Identify the primary drivers of friction between managed care organizations and healthcare providers.
- Analyze how administrative burdens and limited access to key patient information affect provider reimbursement and overall contract performance.
- Evaluate effective models for collaborative communication and claims escalation in managed care.
- Apply data-sharing practices that promote mutual transparency and support meaningful reimbursement comparisons and informed negotiation decisions.

The Current Managed Care Landscape

- Rising financial pressures on providers
- Increasing complexity of managed care contracts
- Growing administrative requirements

Sources of Friction

- Authorization requirements
- Claims denials
- Payment delays
- Credentialing inefficiencies
- Inconsistent contract interpretation
- Limited transparency
- Patient non-compliance

Why Managed Care Friction Matters

- Managed care relationships directly influence reimbursement speed, denial rates, access to care, provider satisfaction, and the length of the contracting process.
- Common friction points include prior authorization delays, claim denials, unclear payer requirements, frequent policy updates, and inconsistent data sharing.
- For leadership, these issues affect margin, contract performance, operational workload, and long-term payer strategy.
- For payer relations staff, success depends on translating payer requirements into clear workflows, escalation pathways, and measurable accountability.

Administrative Burden & Contract Performance

- Administrative burden increases labor costs and slows cash flow when teams must repeatedly touch the same account.
- Delayed or incomplete information can cause avoidable denials, underpayments, missed appeal windows, and inaccurate contract performance reporting.
- Leadership should view these administrative burdens as a strategic risk that can be monitored, reviewed and negotiated, not just an operational inconvenience.
- Payer relations teams can reduce burden by standardizing payer-specific workflows, tracking repeat issues, and escalating systemic patterns rather than isolated claims only.

Moving from Adversarial to Collaborative Relationships

- Historically, payer-provider relationships have centered on disagreements over reimbursement and policy interpretation.
- The most successful organizations focus on transparency, communication, and shared problem-solving.
- A collaborative approach produces better outcomes than a purely contractual approach.

Takeaway: **The best payer relationships are built between people, not just organizations.**

Collaborative Communication Framework

Shared agenda

Focus meetings on measurable issues such as denials, underpayments, authorization delays, and unresolved escalations.

Clear ownership

Assign payer and provider contacts for each issue, due date, and next action.

Evidence-based discussion

Use claim samples, contract terms, trend reports, and policy references rather than anecdotal complaints.

Consistent cadence

Hold routine operational meetings and separate strategic meetings for leadership-level barriers.

Mutual accountability

Track commitments, resolution time, and recurrence after closure.

Claims Escalation Model

Front-Line Resolution

Validate eligibility, authorization, coding, timely filing, and documentation.

Payer-Specific Review

Compare the denial or payment variance against contract terms, payer policy, provider manual language, and historical outcomes.

Root Cause

Evaluate the “why?” Research the reason for the issue instead of escalating individual claims for more efficient outcomes

Formal Escalation

Submit a concise issue summary with claim examples, financial impact, policy references, and requested resolution.

Governance Review

Discuss recurring trends in scheduled payer meetings with decision-makers from both organizations.

Contract Strategy Feedback Loop

Use escalation outcomes to inform future contract language, service-level expectations, and negotiation priorities.

The Importance of Contract Negotiation

- Address system's financial and service line projections.
- Establish business relationships for better payer performance
- Help minimize financial, legal, and operational risks by reviewing key language details
- Compare reimbursement against Medicare, market benchmarks, and comparable contracts.
- Evaluate contract performance using actual claims data, not just fee schedule language.
- Use objective data to support negotiation strategies.
- Improve reimbursement

Data Sharing for Transparency and Negotiation

- Data should support reimbursement comparisons across payer contracts, product lines, service categories, and denial reasons.
- Transparent reporting helps payer relations staff identify operational issues and helps leadership evaluate contract value.
- Useful metrics include clean claim rate, denial rate, appeal success rate, days in accounts receivable, underpayment recovery, authorization turnaround time, and payer responsiveness.

Compare Key Data Fields & Metrics

A defensible comparison aligns the service type, population, period, and payment basis.

Comparison field	Party A	Party B	Decision rule
Service type	Per encounter	Per claim	Convert to common unit
Population	Commercial PPO	All commercial	Filter to matched product
Time period	CY 2025	Rolling 12 months	Use same service dates
Payment basis	Allowed amount	Net paid	Reconcile adjustments
Case mix	None	Severity score	Apply one shared method

A Usable Data Package Answers Four Questions

1. **Scope**
   Which services, populations, products, providers, and dates are included?

2. **Definitions**
   How are allowed amount, paid amount, units, denials, and adjustments defined?

3. **Method**
   Which grouping, weighting, outlier, and normalization rules were applied?

4. **Assurance**
   Who owns the file, which version is current, and how are discrepancies resolved?

Transparency is a Shared Operating Practice—Not a Data Dump

ONE-SIDED DISCLOSURE

Creates friction

- Selective extracts
- Unclear definitions
- Different time periods
- No way to reproduce results

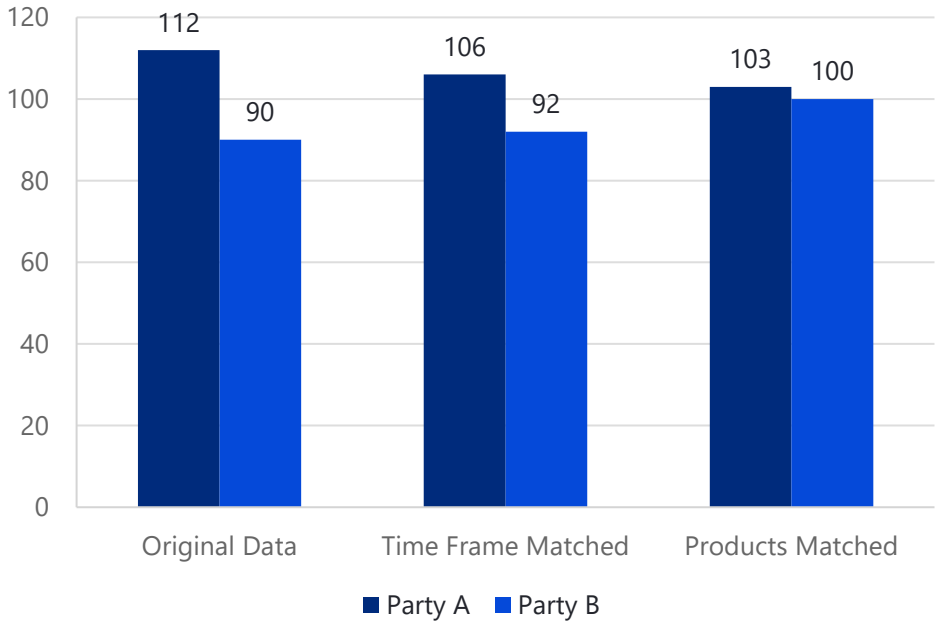
MUTUAL TRANSPARENCY

Creates a common fact base

- Agreed fields and definitions
- Known exclusions and limitations
- Shared data normalization rules
- Documented version and timing

Move from Data Validation to Negotiation in Three Deliberate Steps

Data Normalization Can Change the Negotiation Story



Illustrative index

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- Original data shows how far apart payer and provider are if there is no data normalization
- The next 2 groupings show examples of how that gap is impacted with each additional matched data set
- The apparent 20% difference narrows to 3% after matching product and case mix.

Negotiation implication

Focus the discussion on the remaining 3% and the assumptions behind it.

Develop Strategies to Strengthen Relationships with Payers.

- ✓ **Building Relationships:** Establish trust and rapport with the other party. Strong relationships can lead to more collaborative and mutually beneficial outcomes.
- ✓ **Effective Communication:** Clearly articulate your needs and listen actively to the other party. Use open-ended questions to understand their perspective and find common ground. Maintain regular dialogue with payers to address issues proactively and work towards mutually beneficial solutions.
- ✓ **Flexibility:** Be willing to adapt and find creative solutions. Flexibility can help you navigate impasses and reach agreements that satisfy both parties.
- ✓ **Leverage:** Identify and utilize your strengths and advantages. This could be unique offerings, market position, or other factors that give you an edge.
- ✓ **BATNA (Best Alternative to a Negotiated Agreement):** Know your alternatives if the negotiation doesn't go as planned. A strong BATNA gives you confidence and a fallback option.

"Healthcare is not just about health. It's about dignity, empathy, and connection."


Questions?

THANK YOU

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1573 Mallory Lane Suite 200, Brentwood, TN 37027