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Payer Contract Rate Benchmarking Guide

For FL Behavioral Health & Healthcare Facilities — Know Where You Stand, Know What to Ask For

Most FL behavioral health facilities have never benchmarked their payer rates against what comparable organizations are receiving. **The average facility we work with is reimbursed 15–25% below market on at least one major payer contract** — not because the payer won't pay more, but because no one has asked. This guide walks you through how to assess your current position, identify gaps, and prepare for renegotiation.

STEP 1 — IDENTIFY WARNING SIGNS YOUR RATES NEED ATTENTION

When did you last renegotiate with your top 3 payers?

If more than 18–24 months ago, your rates have likely fallen behind market. Payer reimbursement benchmarks shift annually.

FLAG: 2+ YEARS = RENEGOTIATE NOW

Do you know your rates for every service line you bill?

Many facilities negotiate inpatient detox rates but leave PHP, IOP, and outpatient rates at payer defaults — almost always below market.

FLAG: ANY "DEFAULT" RATES = OPPORTUNITY

Are you in-network with all payers active in your market?

FL has a number of smaller Medicaid MCOs and regional TPAs that most facilities have never pursued — missing even one represents uncaptured revenue.

FLAG: MISSING PAYERS = GAP ANALYSIS NEEDED

STEP 2 — CONDUCT YOUR CONTRACT AUDIT

What to review	What to look for	What a red flag looks like	Priority
Current reimbursement rates	Per-diem or fee schedule rates for every service line — detox, residential, PHP, IOP, outpatient BH	Rates set at contract inception with no escalation clause and no renegotiation since	**High — review immediately**
Contract renewal dates	Auto-renewal clauses, termination notice windows, and renegotiation trigger language	Auto-renewal within 90 days with no rate adjustment provision	**High — calendar all renewals**
Clean claims rate	% of claims paid on first submission. Industry benchmark: 90%+. Best practice: 95%+	Below 85% clean claims — revenue cycle issues are costing you before any rate negotiation begins	**High — fix before renegotiating**
Payer network coverage	Full list of payers you are in-network with vs. payers active in your county	Missing any Medicaid MCO or commercial payer with significant local market share	**Medium — gap analysis recommended**
Medical necessity denial rate	% of claims denied for medical necessity vs. total submitted, by payer	Any single payer with denial rate above 15%	**Medium — track by payer**
Days to payment	Average days from clean claim submission to payment receipt, by payer	Consistently beyond contractual terms — payer may be in breach	Lower — document everything

DOCUMENTATION TO GATHER

- [ ] **Current signed contract** and all amendments with effective dates
- [ ] **12 months of EOBs** by payer — shows actual paid vs. contracted rates
- [ ] **Payer mix report** — % of revenue by payer and service line
- [ ] **Census and utilization data** — average daily census, length of stay, service volume
- [ ] **Quality and outcome metrics** — accreditation status, readmission rates, patient satisfaction
- [ ] **Clean claims rate and denial data** by payer

LEVERAGE POINTS TO DEVELOP

- [ ] **Accreditation status** — Joint Commission and CARF justify premium rates
- [ ] **Geographic access** — if your facility fills a network access gap, payers need you
- [ ] **Volume growth** — increasing census demonstrates demand
- [ ] **Competing payer offers** — in-network status with a competitor validates your rate ask
- [ ] **Cost of care data** — if rates haven't kept pace with inflation, document it
- [ ] **Termination as leverage** — willingness to terminate is your ultimate negotiating card

STEP 4 — NEGOTIATION PRINCIPLES THAT DRIVE RESULTS

01
Never accept the first offer
Payers build negotiating room into initial offers. Average rate increase across Aegis engagements is 7–25% from first offer to final contract.

02
Negotiate service lines separately
Payers bundle service lines to obscure low rates. Negotiate PHP, IOP, residential, and outpatient BH each independently.

03
Time your ask strategically
Best renegotiation windows are 90–120 days before contract renewal. Starting too late locks you in for another cycle.

04
Ask for escalation clauses
Annual CPI-tied rate increases built into the contract eliminate the need to renegotiate every cycle.

05
Know your walk-away number
Calculate the minimum rate that covers your cost of care plus viable margin before negotiations begin.

06
Get everything in writing
Do not accept patients under a new rate until the amended contract or letter of agreement is signed.

WHAT A SUCCESSFUL RENEGOTIATION LOOKS LIKE — AEGIS OUTCOMES

7–25%	18+	$10M+	340
Average rate increase per payer across Aegis negotiations	Payer contracts negotiated across FL and multi-state	New revenue generated through contract optimization	Additional annual admissions generated through payer expansion for one FL client

AEGIS CONSULTING, LLC

Ready to benchmark your rates and find out what you're leaving on the table?

Aegis Consulting offers a Payer Network Gap Analysis — we map your current network, benchmark your rates, and quantify the revenue upside before you commit to anything.

Free 20-min call
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