

Maximizing Contract Revenues—Managing What You’ve Negotiated

Negotiating financially sound contracts with health plans and other entities is clearly a critical step toward hospital and provider financial success in managed care. Profits from rates and terms negotiated, however, can only be realized if the contracts are managed as intended. That sounds simple, yet many hospitals and other provider organizations are missing by a long shot. For many at-risk provider organizations, millions of contract revenue dollars are lost each year – and no one knows it is happening.

- Why?**
- ❑ Misunderstanding – lack of information and comprehension about managed care, contracts, terms, requirements and their implications – throughout all levels of the organization
 - ❑ Limited and/or insufficient information systems
 - ❑ Inadequate operational controls.

Too often attention is focused on reducing services or reducing costs of services in order to maintain profitability under managed care. However, tremendous financial gains can be achieved simply by assuring information is accurately processed, and full advantage is taken of the financial safety provisions already included in most contracts. These six steps can guarantee you greater profitability:

1. Educate

Although the constructs of managed care may seem fairly clear to the management involved in planning and contracting, many aspects of managed care are still a mystery to others in your organization – most of whom are in a position to significantly impact your revenues.

If your staff was trained in the fee-for-service era of medicine, identifying the insurance carrier and effective dates of coverage were the only necessary pieces of information for financial reimbursement. Managed care adds significantly more complexity:

- ❑ Each insurer now offers multiple products (e.g., indemnity, HMO, EPO, PPO, POS, etc.) and, very often, hundreds of plan variations within each product offering.
- ❑ You have most likely negotiated separate contracts with differing rates and terms for each insurer, product and sometimes each individual plan – sometimes capitated, sometimes discounted fee-for-service and frequently a mix of both.
- ❑ Specific services included and excluded within each contract probably vary as do the administrative rules that apply (e.g., pre-notification, prior authorization).
- ❑ Who to call for administrative compliance could be almost anyone, depending upon the insurer, product, employer, patient’s chosen delivery system (or primary care physician) and your relationship to that delivery system.
- ❑ Rates, co-pays and/or write-offs will also depend on this delivery system relationship.
- ❑ All of the above points vary by different sets of effective dates.
- ❑ Unless all management and staff within your organization understand managed care – its terms, complexities and the specifics of your contracts – significant, costly errors can occur.

Provide a comprehensive “Managed Care 101” course for all management and staff within your organization with particular focus given to your specific contracting approach, relationships and contract provisions. As your staff’s understanding of managed care contracting increases, potential and actual

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operations problems and costly errors will quickly come to light. Recognition is the first step toward correction.

2. Communicate

If you are involved in managed care contracting, documents seem endless and status is in constant flux. Very often, patients covered by your contracts seek care before critical operational departments are even aware a new contract has been negotiated. To avoid expensive submission and processing errors, it is essential to establish and maintain excellent coordination and communication between the contracting and operational departments. Developing an effective communication process for notifying all necessary parties of new contracts and amendments will allow you to take immediate advantage of financial benefits negotiated.

Communicate the specifics of contracts in a meaningful way to your departments. What may appear to be a clear and straightforward process to you during contract negotiations can often lose much of its clarity when your staff is confronted with real life instances requiring interpretation. For example, does a risk or payment term for Diagnostic Testing include colonoscopy, or is colonoscopy considered an outpatient surgery? Do all outpatient radiology professional fees fall under physician risk, or are some intended to fall under hospital risk if the radiology interpretation fees are associated with a hospital risk service? Do oncology professional services include administration of chemotherapy and/or the cost of chemotherapy drugs?

Reduce misinterpretation by specifically defining categories, service types and services using standardized codes (e.g., CPT, revenue, HCPCS, etc.). Establish standardized coding ranges (e.g., Diagnostic Testing includes 91010 through 91052 and 70010 through 76999, etc.) across contracts regardless of insurer, product, plan, etc. Develop concise reference documents to summarize financial and administrative responsibilities for each set of services, using your standardized codes for all contracts. Document limits, thresholds and payment formulas in straightforward terms.

3. Re-assess Roles and Modify Processes and Procedures

Many organizational roles and responsibilities originally established to support the fee-for-service environment must be revamped to support managed care business (e.g., insurance and eligibility verification, A/R monitoring of payment for correct negotiated fees, revenue planning, COB, etc.). Additionally, the clinical and financial requirements of managed care have forced the creation of new functions and roles within the provider environment. To avoid costly errors and maximize recoveries, your organization must review your processes, systems, roles and skill levels to support key managed care functions. Common points of error are:

- ❑ **Eligibility Verification** Determine not only insurance coverage, but also financial and administrative responsibility, copayment obligations and pre-notification/approval needs. This information, in conjunction with referral source and PCP/delivery system assignment, will help define the correct contract for the patient and establish the correct financial class/plan type for financial processing.
- ❑ **Capitation Reconciliation** Validate eligibility lists and capitation checks you receive for correct pre-payments. Too often providers rely on the accuracy of insurance information systems that do not necessarily warrant this level of confidence. Retroactive changes to eligibility, benefits, patient provider affiliations and contracts could have occurred which would allow for adjusted billing and/or recoveries. Be sure to assign the specific responsibility of reviewing the financial impact of these retroactive changes.
- ❑ **Service Specific Processing** Put controls in place to identify terms for special pricing and to allow for intervention. Improved systems could assist with flagging services for special contract provisions,

but most organizations still rely heavily on manual processes. These manual processes are often not effective for accurate identification and proper handling of outliers, carve-out services, global fees, all-inclusive per diems, etc.

- ❑ **Stop Loss/Reinsurance Recovery** Protection against the financial impact of high-cost cases may be achieved either through cash payments or withholds under risk contracts. Frequently, the tracking and reporting processes are manual and error-prone. Review your process for identifying and tracking instances where care is nearing cost thresholds and report cases that meet and exceed limits within the established time frames. When subcontracts exist for services for which the provider organization is at risk, be sure costs for these referred services are included in threshold calculations. Additionally, internal capitated charges often have fee-for-service equivalents that should be included in reinsurance calculations. Be sure to include all possible costs to maximize recovery.

The lost revenue for these errors can be substantial. As an example, Outlook Associates assisted a 600-bed hospital with capitated financial risk for inpatient services in discovering over \$2 million in errors during an 18-month period. Staff in the registration and insurance verification areas misunderstood that multiple capitation, fee-for-service, and mixed arrangements could be in place for the same period with the same health plans. This misunderstanding, combined with system limitations in classifying insurers and plans, resulted in \$1.2 million in erroneous write-offs. Another \$1.1 million resulted from a lack of consistency among contracts for including and excluding a small set of very expensive services from capitated risk. The systems were set up to accommodate the most common default, “covered under capitation,” and large dollar billable charges were written off to capitation expense.

Review your operational performance measures. Incentives for timely accounts receivable are no longer sufficient when larger levels of revenue come from capitation and incentive programs. A/R can appear quite timely when the majority of charges are being written off to capitation expense (whether or not they are being written off correctly). In many cases, significant revenue (e.g., incentive pools, shared risk pools, etc.) is determined from data and performance reporting that is not within your organization’s control. For example, a health plan continues to pay claims for specialty services for which the provider organization is at risk. In these circumstances, it is critically important that you establish performance measures that gauge the correct incentives under managed care and have control of the data to measure that performance.

4. Automate

As financial risk to your organization is increased through managed care contracting, so is your need for more sophisticated information systems to help manage that risk. If you assume financial and administrative responsibility for services you subcontract to provide, suddenly you take on the roles for authorization and claims payment. If you negotiate global risk contracts, suddenly you have a critical need for full case management processing. Your fee-for-service systems can still handle the fee-for-service business, but they must be supplemented to support new functions and reporting needs for managed care. Acquiring the right system components to support your specific managed care contracts and strategic direction will be one of your most critical components of success.

Computers are ideal for identifying contracts that are defined using standardized codes and rules. Good, properly implemented software can easily calculate copayment/co-insurance amounts, re-price claims according to negotiated rates, write-off capitated service charges and route claims to the appropriate party with financial and/or administrative responsibility. More sophisticated software packages can electronically determine eligibility, benefits and referral status, monitor benefit and stop-loss accumulators, reconcile capitation dollars, track risk pools, and handle a large number of managed care financial, clinical and administrative functions.

Once acquired, implementing and configuring your systems to correctly identify your contract complexities is your next most crucial step. The ability of a system to “automatedly” manage the contract

terms is totally reliant on the accuracy of the input of those contract terms into the system tables. One of the more frightening realities is that a system can erroneously write-off charges as quickly and easily as it can accurately do so. A skilled, well-trained contract analyst is mandatory to assure accurate contract interpretation within your information systems.

5. Audit

Audit areas of greatest financial exposure to protect your organization and take full advantage of the financial safety provisions negotiated in your contracts. The best systems and best processes can still have problems and some errors will occur. Periodic audits should be scheduled from the beginning and throughout the term of any contract to identify and correct system configurations and procedures as necessary. Most organizations do not conduct audits until negative financial performance is documented – locking the proverbial door once the horse (or money) is out of the barn. In some instances of error, recovery is possible. Recovery is, more often than not, negotiated and rarely returns your full dollar. Proactive audits are the key.

6. Collect All Data Possible

Everyone will agree that profitability analysis of your existing contracts is the key to negotiating even more profitable contracts in subsequent years. Profitability analysis requires complete data on services provided, the costs of delivering those services and all other costs associated with the contract. Unfortunately, information systems and financial analysis departments, having evolved from the fee-for-service era of healthcare, are too often focused on billing transactions. But billing transactions do not provide the means for collecting data on services provided unless specific fees are associated with those services. For example, if a patient is covered under a capitation agreement or if per-diem or case charges are in effect, recording specific service line items is commonly eliminated as a time savings effort or to prevent incorrect billing transactions. In these circumstances, critical data for contract profitability analysis is lost.

Often, vital data is also missed when subcontracts exist for some services under risk, especially if subcontracted providers accept part of the financial risk through capitation/subcapitation agreements. Negotiate your contracts to specify requirements for timely data submission, and just as importantly, evaluate information systems within your organization to determine their capability to support the capture and use of this external data. Standardize coding within your organization to make data analysis far more accurate and easier to accomplish. The development of relational databases and excellent reporting tools are essential.

A cost often ignored, but surprisingly high, is the cost of infrastructure needed to support your negotiated contracts. Information systems limitations and costs should not dictate the flexibility of your contract negotiations. However, the cost of administering complex contract terms should.

The financial terms of your managed care contracts are, at best, actuarially determined using good data on health risks, services levels and regional costs. No factor is added to account for operational errors. With reasonable luck in attracting healthy membership, good management of appropriate care and good cost control, the financial terms of your contracts should assure you fair profits. Your information systems and additional staff may carry high price tags, but not as high as the cost of errors without automation and well-trained people in place to manage what has been negotiated. Maximize your profit opportunity by managing your contracts to their fullest potential.