



Manage Your Payer Contracts to Optimize Collections



To Our Healthcare Clients and Friends:

Could you be receiving underpayments from as many as 40% of your payers? It's possible. Underpayments are among the major challenges hospitals face today, whether the result of complex or ambiguous contracts, inadequate information systems, or other contributing factors. In this edition of *Insights*, we will discuss steps you can take to position your hospital or health system to better manage your payers, instead of allowing the payers to manage you. We'll note some of the issues associated with problematic contracts, and we'll offer suggestions to help you negotiate realistic contracts that can be utilized to confirm payment accuracy or to identify underpayments. After all, if your revenue cycle team is not sure how much should be paid on a claim, how can you expect to collect the correct amount? Properly negotiated contracts are an important element in optimizing cash collections.



BACKGROUND



Contractual underpayments are widespread, can be difficult to identify, and result in millions of dollars of lost revenue for healthcare providers. Unlike payer denials, which also result in significant lost revenue, it is not as obvious when a hospital receives an underpayment. Most hospitals are able to accurately estimate reimbursement for Medicare, Medicaid, Blue Cross, and of course, Self-Pay accounts. Many are not as successful when it comes to estimating the amount due from their remaining payers, which may total as much as 40% of their payer mix. If the actual amount due is unknown, and if contractual allowances are simply being posted in accordance with the remittance advice, legitimate payment variances will go undetected, resulting in inflated contractual allowances and reduced net revenue.

Revenue Integrity Teams are becoming popular as one aspect of the overall revenue cycle organization structure. Among their many duties, most of which focus on enhancing net revenue, Revenue Integrity Team members are responsible for identifying and collecting payment variances. If they are working with clear, concise contracts, and if the terms of those contracts can be successfully entered into a contract management system or module, they will be far more successful.

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It is nearly impossible for revenue cycle staff to “manage to the contract” when dealing with ambiguous or complex contracts. Providers may suspect that payers take advantage of such contracts by intentionally underpaying claims. It seems unlikely that payers would risk the adverse publicity and potential penalties associated with conducting business in this way. What appears much more likely is that payers face the same types of constraints in adjudicating claims as providers face in determining if the claims were paid correctly. For example, payers would generally be more comfortable than their provider counterparts in working with complex contracts; but their information systems may be no better in that regard than those of the hospitals. An unintentional payment error on the part of the payer, coupled with an inability on the part of the revenue cycle staff to identify that payment error, would almost always mean the hospital received a lower reimbursement than the amount to which it was entitled.

CHALLENGES

Many institutions struggle with netting their accounts receivable (A/R) at the time of billing because of the effort required to do so, the limitations of their information systems, or because of the lack of clarity or the excessive complexity in their payer contracts. Any or all of these factors may come into play; and this leads some hospitals to simply choose to apply contractual allowances at the time of payment, while others implement processes that permit inaccurate contractual allowances to be applied at the time of billing. There could be several challenges providers employing these strategies may encounter, including, but not limited to, the following:

- Net A/R will not be an accurate reflection of what is truly due from the payer.
- The hospital is unable to accurately predict cash collections.
- Revenue Integrity Team members or other follow-up staff must function without an easy and dependable way to identify legitimate payment variances.
- Revenue cycle management cannot reliably measure billing and collection performance via standard industry key performance indicators such as percentage of net revenue collected.
- Credit balances may be inflated due to incorrect contractualization. Posting an incorrect contractual allowance amount is a major cause of credit balances. If a hospital nets A/R at the time of payment based upon a payer's remittance advice, it is relying on the payer's interpretation of the contract; and any mistakes the payer might have made in calculating the amount of payments and/or allowances will affect the hospital's net revenue.
- Contractual allowances, co-insurance, deductibles, and write-offs will not be accurately identified and posted.
- True payer performance cannot be evaluated, monitored, or tracked.

There are just too many pitfalls surrounding the adoption of strategies and implementation of processes that permit netting A/R at the time of payment or netting A/R inaccurately at the time of billing. Few hospitals can afford the financial ramifications. And that brings us back to the question of how to deal with the payer contracts that gave rise to so many of the challenges noted.

INSIGHTS

To begin the process of managing your payers, key staff in the facility must have a thorough understanding of payer contracts and issues. This can be accomplished by reviewing all existing payer contracts, one payer at a time, beginning with the highest volume payers. An issues log should be maintained for each major payer, so information regarding the execution of contracts can be accessed easily. An incremental approach to the reviews will allow the team to refine the process as more and more payer contracts are reviewed. On an ongoing basis, contract reviews should also be performed when contracts are up for renewal or when the hospital negotiates new contracts with payers. Feedback from the reviews, and from actual experience with payers, should be provided to the individual(s) responsible for negotiating contracts.



A task force is the ideal forum for this process. Championed by the CFO, the task force will include a representative from the hospital's Managed Care Team, as well as those department heads whose operations are impacted. Typically, there would also be department head representation from Patient Accounting, Patient Access, Reimbursement, Utilization Management, and HIM, with input from respective ancillary departments and Legal, as needed. The responsibilities of this task force will include the following:

- Review proposed (i.e. new) contracts, and provide feedback regarding operational implementation of the provisions, terms, and conditions. If the hospital has contract history with the payer for other services, now or in the past, be sure to evaluate how the payer performed under the terms of those other agreements. In the case of renewal contracts, review the payer's performance during the most recent contract period.
- Discuss ongoing managed care and other payer updates (e.g., Bulletins, Third Party Administrator changes) and develop action plans to facilitate any necessary changes and to communicate those changes to the appropriate parties.
- Modify existing contracts if, at some point during the contract period, an ancillary department begins to perform a new service. This will be particularly important if the new service is a high-dollar addition to the service line.
- Distribute new rates for implementation, ensuring that all who need them receive them and that the associated charge description master updates are completed. How often has it happened that you discover "after the fact" that your rates have changed? A proactive rate change process will eliminate the need for manual intervention to resolve affected accounts.
- Identify, track, and discuss operational, reimbursement, and late payment issues. Develop and implement strategies to resolve the issues. Develop a payer scorecard to evaluate and monitor payer performance.
- Invite payers onsite to provide education on specific topics or to discuss and resolve issues. Identify any opportunities for improving their systems or operations to ensure compliance with the contract. In some cases, it will be beneficial for one or more members of the task force to visit a payer's site, as well.

In support of the contract review process, it is helpful to create a template or fact sheet identifying the hospital's standard contract provisions, terms, and conditions. When negotiating a new contract, a matrix can then be developed to match the components of a payer's proposed contract with those of the hospital's standard agreement to determine the areas that will require negotiation and compromise. This will help the team conducting the reviews, as well as the contract negotiator ensure the hospital's standard requirements are met. Below is a partial list of steps to take in reviewing the contracts:

- Check to be sure existing contracts are current, with appropriate effective dates.
- Identify and define all levels of service in the contract, with corresponding rates. Confirm that high-cost procedures are carved-out at higher reimbursement rates and not paid at a per diem or outpatient rate. Ensure the contract is specific enough to meet the requirements for various payment structures (e.g., revenue codes, CPT codes, fee schedules).
- Identify and define "excluded" services in the contract.
- Clarify any ambiguous terms in a new/renewal agreement.
- Ensure all fee schedules are received from the payers.
- Incorporate fees for copies of medical records.
- Ensure the payer is capable of remitting electronically (ANSI 835). This will allow you to post payments and denials electronically, saving staff time and improving accuracy. It will also facilitate moving the co-insurance and deductible amounts to the next payer or to the patient in the system. NOTE: Educate your follow-up staff on the contract terms and the way in which the system is set-up to net the receivable. This will allow them to be knowledgeable and firm in following-up on payment variances.
- Define a "clean claim" as one that meets the ANSI 837 standard, as mandated by HIPAA.
- Identify time frames for receipt of payment for clean claims, adding late fees for payment delays. Many states have prompt payment regulations, which can be incorporated into the contract.
- Ensure that any volume-based discount provisions include a periodic review period to determine if the volumes meet the requirement for the discount. Include a clause in the contract that enables adjustments to the discount, if indicated.
- Consider replacing "direct cost" or "cost plus a percentage" contract provisions with "percentage of charge" provisions. Cost is often not loaded in your patient accounting system, so "percentage of charge" is easier to administer.
- Ensure there is a process to identify and manually apply contractual allowances for any items for which contractual allowances cannot be automated. This should be determined prior to finalizing the agreement, to provide an opportunity to renegotiate if a viable process can't be developed.



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After you have negotiated the most advantageous contract provisions, terms, and conditions possible, it is necessary to set-up the contract management system or module properly to support billing and collection processes. The ability to automatically and accurately net the A/R at time of billing is critical. The patient accounting contract management system or module should be set-up to calculate reimbursement for each level of service. This might require you to consolidate or create insurance plan codes and/or new service levels.

SUMMARY

Implementing these recommendations and utilizing a team approach will help the hospital manage its payers and payer contracts, and will ensure the hospital is in the best position to capture all reimbursement owed for services rendered. Before signing any new or renewal contract, be sure to conduct a due-diligence evaluation of the payer's performance in past contract periods.

It is the provider's responsibility to ensure its payers operate in accordance with contract terms, and to identify and recover any underpayments. Providers that take prudent measures to manage their payer contracts and relationships will help to secure the financial stability of their organizations.

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We are pleased to have the opportunity to present this information to you. If you have any questions or need assistance in developing strategies to better manage your third party account receivables and the payer contract process, please contact me at (610) 517-1386.

Truly yours,

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