"Managing" Managed Care

Dennis Moore, Obsidian
Amy Groten, Katz Brunner Healthcare
Melinda Brunner, Katz Brunner Healthcare

Contract negotiations are complete; your managed care contracts are in place … now the real work begins. "Managing" your contracts on the back end is as important as what you negotiate on the front end for all payor types, including Medicare Advantage and Managed Medicaid. Understanding the parameters and administrative and financial expectations of negotiated agreements will maximize contract benefits as well as minimize challenges.

There are three primary phases involved in "managing" managed care:

1. Contract Set Up / Organization Preparation
2. Measure Contract Performance
3. Ongoing Compliance

Contract Set-Up / Organization Preparation

Whether an organization has signed an agreement with a new payor in the market or simply updated paper and / or rates with an existing payor, it is imperative that providers identify and load accurate information into contract management systems. In addition to reimbursement rates, carve-outs and stop-loss provisions, provider organizations should track impactful administrative requirements that could include:

- ✓ Timely filing and payment dispute provisions
- ✓ Prompt payment requirements
- ✓ Processes and / or limitations for adding new providers, locations or service lines
- ✓ Initial term and termination rights, renegotiation periods
- ✓ Data submission requirements and obligations (i.e. payment audits, HEDIS, quality measurements)

Providers should also develop and maintain a quick reference guide, outside of the contract management system, with the preceding information that can be distributed to applicable staff members.

In addition, registration staff should be provided with sample ID cards for all new payors as well as standard processes for securing prior-authorization, managing the filing and editing of claims, and adhering to various other Utilization Management requirements.

Providers should take advantage of online tools and resources made available by the payors to assist in navigating administrative and care coordination requirements, including online prior authorization and claims management functions. For all payors, designated staff should enroll in online Provider Portals and participate in available training and webinars. These portals may also serve as the only avenue for accessing provider policies and manuals, making online access even more imperative for relevant staff members.

Don't lose precious reimbursement on "avoidable" issues because staff wasn't prepared or had inaccurate information on payor requirements / expectations.

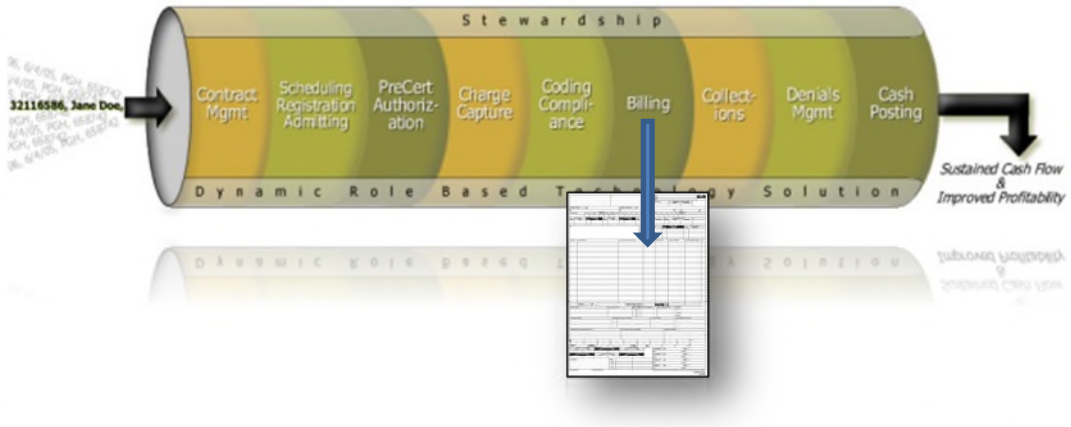
Measure Contract Performance

At the end of the day, successful business management is about "*outcomes*," not "*processes* – "***results***" not "***activities***." So how does an organization measure the effectiveness of any given managed care contract to compare expectations to reality?

Clean Claims

The purpose/objective of the healthcare revenue cycle game is to receive complete expected reimbursement in a timely manner. This is successfully accomplished with a high clean claim rate.

A clean claim should be defined as a *complete*, *accurate, and compliant* bill, calculated and formatted for services rendered that ensures its *complete* payment in a *prompt* and *timely* manner the first time, all within focused patient satisfaction, compliant with governmental regulations and with little or no human follow-up.

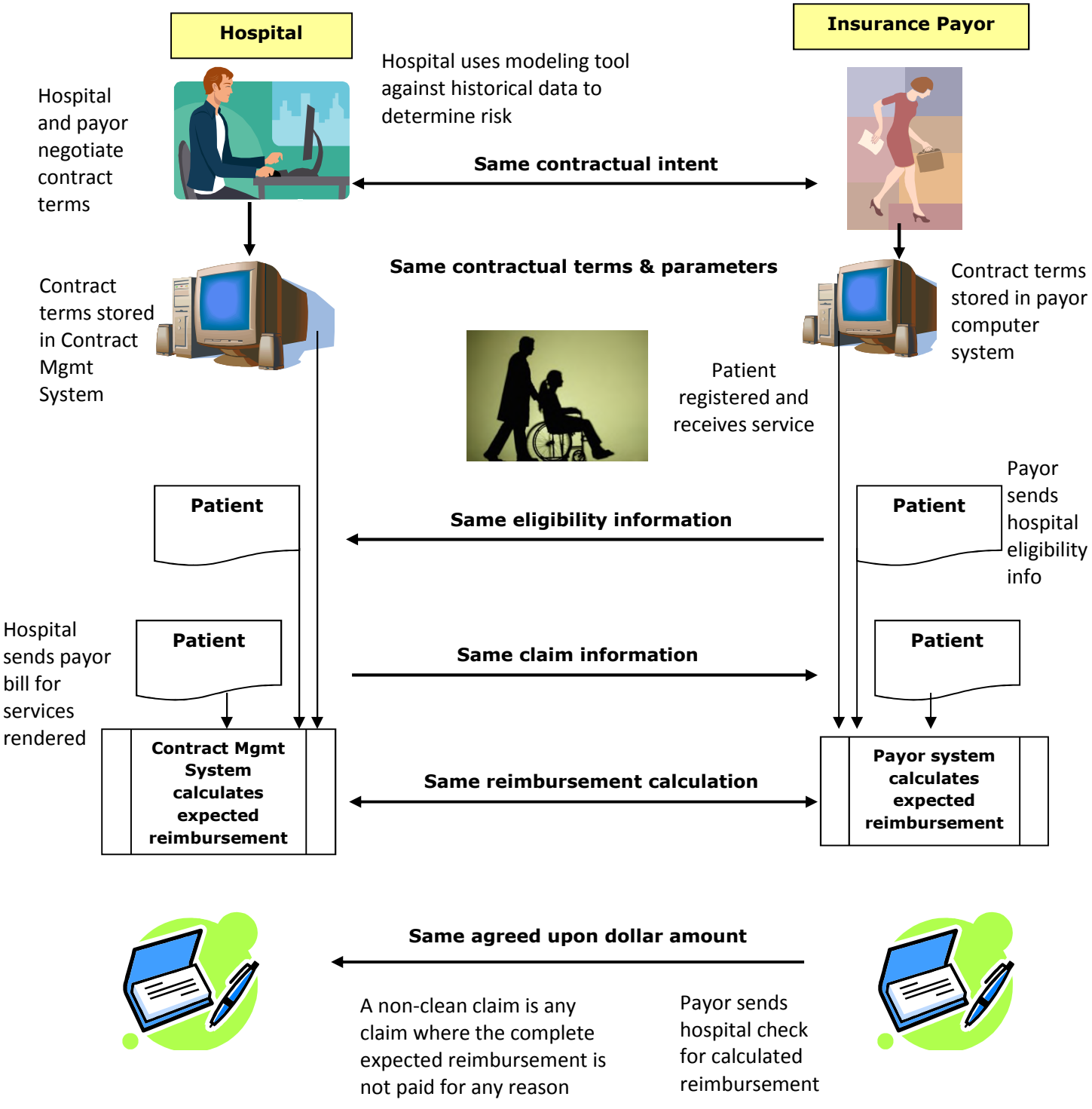


Using this comprehensive definition of what constitutes a "clean claim," the goal, of course, is to have a 100% clean claim rate. Arguably, the "clean claim rate" is the most important Key Performance Indictor (KPI) for the healthcare revenue cycle. Unfortunately, what passes as a "clean claim rate" in today's marketplace is woefully inadequate in its measurement. For example, some facilities use the claim edit report as its sole source for measurement. Ideally, a clean claim rate is the outcome of a comprehensive, fully integrated database and revenue cycle solution.

A subset of the overall "clean claim rate" is a "payor contract clean claim rate." What percent of all claims for a specific payor were *complete*, *accurate, and compliant*, correctly calculated and formatted for services rendered, billed and paid on time with no denials or problems? In addition, the organization should be able to break down each component of the clean claim rate criteria to quickly identify where problems exist.

How to Identify Problem Claims

Visually, the process should work as outlined below:



So in summary:

Same intent + same stored terms + same eligibility info + same claim info + same reimbursement calculation = same agreed upon dollar payment

When the insurance payment equals the calculated estimated insurance amount, then everything works fine. But when the insurance payment is different from the expected reimbursement as calculated by the provider's *Contract Management system,* then we have a problem. Since both systems should be using the same parameters and claim information to calculate payment, then it is likely that one or more of the following conditions has occurred if there is a payment discrepancy:

1. Without realizing it, hospital and the insurance rep have some disagreement about how a particular aspect of the contract should be interpreted.
2. The final contract parameters entered into the hospital's *Contract Management system* have somehow been entered incorrectly or the system is incapable of doing the proper calculation.
3. The hospital's *Contract Management system* computer program that calculates the estimated insurance payment amount has some kind of bug in it and is calculating incorrectly even though the contract parameters have been entered correctly.
4. The hospital's *Contract Management systems* computer program does not correctly use the specific patient eligibility information in calculating expected reimbursement.
5. The final contract parameters entered into the *insurance company's payment system* have somehow been entered incorrectly or the system is incapable of doing the proper calculation.
6. The *insurance company's payment system* computer program that calculates the insurance payment amount has some kind of bug in it and is calculating incorrectly even though the contract parameters have been entered correctly.
7. The *insurance company's payment system* computer program does not correctly use the specific patient eligibility information in calculating expected reimbursement.
8. A representative from the *insurance company* reviewed the claim and has overridden the payment terms for some reason.
9. A new rule, regulation or contract term (which has *not* gone through the normal contract process) has been unilaterally added to the insurance company's proration program.
10. The hospital has not met required billing specifications.

Problem claims frequently manifest themselves as:

- Denials (which should be tracked and trended by reason and rates)
- Rebills (which should be tracked and trended by reasons and rates)
- Denied Resubmissions (which should be tracked by reason – rates of successes and failures)
- Appeals (which should be tracked by reason – rates of success and failures)
- All problem claims should be identified, tracked and trended by faulty policies or procedures, and personnel or technology issues

Profitability

Many providers use revenue to determine the financial impact of any contractual commitments to the organization's bottom line. However, to make financial information meaningful, it must calculate *profitability*, not just *revenue*.

This principle is true for both "for profit" and "not-for-profit" entities. "Not-for-profit" is a tax status, not a mission statement or the condition of a successful income statement. In order for any organization to stay in business for any significant length of time, revenues must exceed expenses. Unprofitable services are *never* made up in volume.

For example, some years ago one hospital's marketing department recognized a new, large development of homes was underway a several miles from the main facility. A proposal was made to build an off-site OB/GYN facility nearby to handle the large increase in the expected number of births which should in turn increase the organization's revenue. The proposal was almost approved when a cost report revealed that the organization was actually losing $100 on each birth.

So while "total charges" and "net revenue" are useful information, cost information from your cost system is a critical ingredient in this process and making sound decisions. An organization's profitability is generally expressed as "*Revenue – Expenses = Profit*." Account/claim profitability is calculated as "*Payments (net revenue) - Cost = Profit*." Unprofitable accounts don't help the organization's bottom line. Tracking individual account claim profitability, as well as, "winners & losers" group analysis (patient type, hospital service, payor, DRG, etc.) can help with strategic planning, decision making, and effective contract management. And remember, "Returning to profitability is *not* dependent upon significant revenue growth."

As you begin this process, keep in mind that, generally speaking, cost data from your cost system equates to the clinical expense associated with providing any particular service. Any additional data, procedures, special practices, time, equipment, or resources that providers are contractually obligated to provide, is likely an additional expense and cost. Further, an ever-growing cost in today's health provider market is regulatory costs. Providers should include these additional cost factors when evaluating contract performance.

Reporting / Penalties

After analyzing data and measuring contract performance, findings can be reported and used to target payors who fall below benchmarks based on both the organization's expectations as well as their peer groups of other payors.

Generally, the purpose of any contract is to work out a set of terms which are beneficial and agreeable to both parties. However, *payors* penalize *providers* by way of denials when they don't meet contractual criteria. These penalties have teeth because payors simply withhold payment. Providers must then exert considerable effort to overturn such penalties and get correctly reimbursed.

Less common is the notion of *providers penalizing payors* for missing targets. For example, a contract might state that payment will be made by the payor within 30 days from bill submission date. Some states even have "prompt pay laws" which regulate how quickly payments need to be made. But most providers have no system in place to track payor penalties and ultimately, these kinds of negotiated terms have no teeth and simply become unfulfilled "targets." Providers can complain to the payor but there is typically no financial incentive for the payor to comply or improve practices.

In addition to timely payment, there are other factors which could legitimately be discussed or negotiated with payors. For example, requests from the payor for rebills or additional information (i.e., medical records, detail bill, etc.) result in additional costs to the provider. Since in most cases a standard UB04, 1500, or 837 should be sufficient to get the billed paid and because there is an additional cost to the provider to meet these extra requests, it seems reasonable that the payor should share in the cost of compiling and sending this additional information. This would ensure additional information is really needed and not just some payment stall tactic.

Overturned denials are another example of additional unbilled provider costs that must be exerted to receive appropriate and due reimbursement. Beyond the additional cost incurred by the provider to meet these demands, providers have reason to be suspicious that payors use these tactics to delay payment and improve payor cash flow. Automation in this area can be a substantial help.

Ongoing Compliance

In addition to monitoring the financial and administrative performance of managed care contracts, providers must also keep up with administrative requirements and modifications enacted through various material amendments, payor bulletins and provider manual updates. Many times, such unilateral payor changes run counter to negotiated terms and may have adverse administrative or financial implications along with the provider's unintended participation in new products. For example, payors may unilaterally modify ancillary fee schedules or billing requirements, requiring providers to evaluate potential financial impacts and update system processes to comply with the change.

Payors issue amendments and contract updates via several methods including mailed notifications, network newsletters, updated Provider Manuals and via online provider portals. Given the potential impact of these unilateral changes, providers should identify a central contact to receive, review and distribute such notices to appropriate staff members and departments. In addition, providers should be sure to update notice contact information with payors whenever staffing changes occur. Providers may miss out on dispute opportunities / time frames simply due to notifications not reaching appropriate staff timely.

Given the volume of issues that require monitoring, Providers should foster mutually beneficially relationships with local payor representatives. By encouraging open and frequent dialogue with payor reps, providers will have an opportunity to discuss various claim denial and payment issues, administrative challenges and unilateral contract modifications.

Strategic Impacts of Managed Care Management

With the appropriate data and resources in place, your organization will be able to strategically evaluate its managed care contracts to determine which ones need to be tweaked, renegotiated or possibly terminated altogether.

In today's managed care environment, updating or renegotiating a contract to improve administrative or financial terms is a challenging but necessary process that becomes nearly impossible without the knowledge of where the contract falls short, what needs to be improved, and which parameters become deal-breakers.

Is your organization "managing" your managed care adequately?