

Drive Your Hospital's Net Revenues

The Managed Care portion of a hospital's net revenue represents the biggest likely opportunity to positively affect net revenue. Success is reliant on the level of professionalism brought to this task, which must be exceptional in today's competitive environment. What is the key to mastering managed care and in turn drive your hospital's net revenues?

The Key

You change your hospital's payer mix and, in turn, drive your hospital's net revenues by effectively managing your managed care relationships. The key to doing this is by asking how your hospital can improve. How can you improve the way you prepare for negotiations? How can you improve the way you conduct negotiations? And how can you improve how you measure and monitor your results? There's only one answer to these questions: data. This paper conveys a process that will result in maximization of net revenue

MASTERING MANAGED CARE TO DRIVE THE SUCCESS OF YOUR HOSPITAL

*A QHR
White Paper*

By:

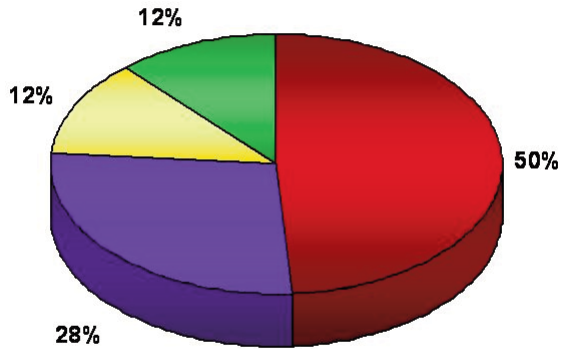
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Question

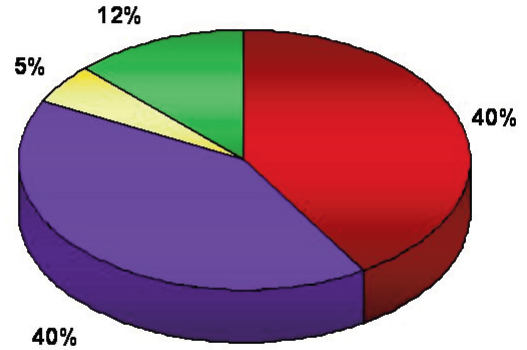
If you could change your hospital's payer mix and, in turn, drive your hospital's net revenues, would you do it?

Classic Hospital Payer Mix



■ Medicare ■ Managed Care ■ Medicaid ■ Self-Pay

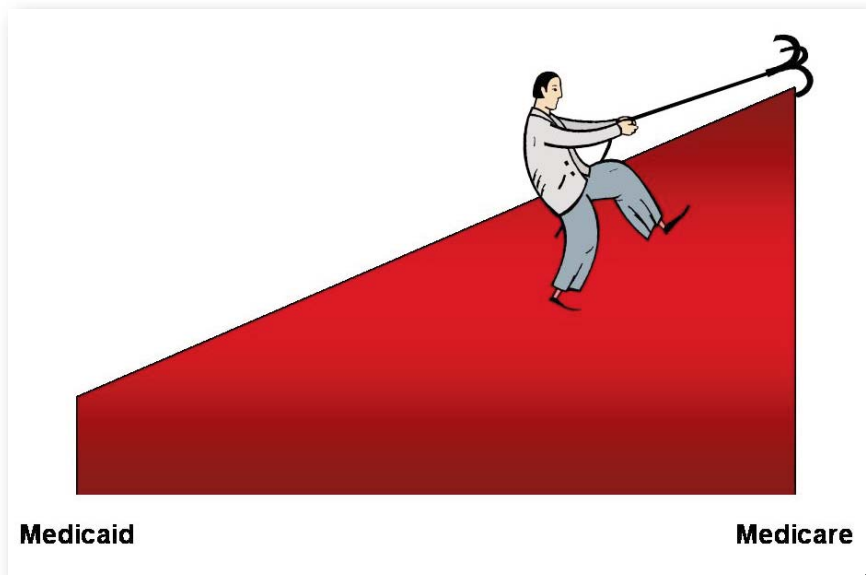
A Scenario that Will Grow Your Net Revenues!



■ Medicare ■ Managed Care ■ Medicaid ■ Self-Pay

A Dilemma?

Consider the classic hospital payer mix—the current mix for many hospitals—where Medicare accounts for 40 to 50 percent of a hospital's net revenues. Then add 5 to 12 percent for payers that come from Medicaid and the sum suddenly seems to make it virtually impossible for a hospital operating under this mix to easily impact its outcomes.



Effectively Managing Your Managed Care Relationships

The key to mastering managed care is asking how your hospital can improve. How can you improve the way you prepare for negotiations? How can you improve the way you conduct negotiations? How can you improve how you measure and monitor your results? DATA. Collecting the right, accurate data is the foundation for unlocking the answers to these questions and enabling you to drive your hospital's net revenues.

Primary Sources of Data

There are a number of sources of data that can help you master managed care in your hospital, including:

- **A current contract matrix** puts the details of your hospital's various managed care contracts at your fingertips. It provides information including contract effective dates, contract termination dates, renewal details, and notice of non-renewal and termination without cause details. It also provides a snapshot of your reimbursement rates.
- **Payment appendices** tell you what your contract is really expected to pay. The appendix is needed as the matrix only includes high-level payment rates.
- **Complete agreements** that are readily available to your PFS staff ensure that you and your staff can dig out contract details when you need to.
- **Insurance plan mapping.** Insurance plan mapping to the correct contract must be updated for you to accurately track payments.
- **A manageable inventory of insurance plans.** Hospitals tend to struggle with too many insurance plans, which can put a strain on the flow of information. Reduce the number of plans your hospital works with, if possible.

Using Data to Monitor Your Managed Care Relationships

Once you have collected your data, there are two different ways of using this data to determine if you are being paid and, of equal importance, being paid correctly: variance logs and automated contract management systems.

Although **variance logs** are input manually, they can be an effective means of monitoring your managed care relationships. They capture information, such as:

- Date of service
- Patient number
- Payment date
- Charges
- Expected payment
- Actual payment
- Variance
- Insurance plan
- Managed care contract
- Date of follow-up
- Status of payment and reason provided

Information in the "date of follow-up" and "status of payment and reason provided" categories can really help your hospital capture low-hanging fruit...unresolved money that is just sitting out there.

Automated contract management systems provide real-time, automated data. But while these systems are great for providing data, they also require a significant investment of resources (to manage the system and keep it up to speed) and are not cost-effective unless you are a high-volume hospital.

And Don't Forget Retrospective Payment Reviews

An alternative to an automated contract management system is a retrospective payment review (RPR), which can be conducted by a retroactive payment group. While these reviews may cost your hospital 20 to 30 percent of the fees collected, it's important to remember that without them, these fees wouldn't be coming through the door at all. RPRs are also a means of finding denied and partial-payment claims. These tell hospitals where they're dropping the ball – whether that means case management may be missing things on the front end or, perhaps, physicians aren't getting the required pre-authorizations.

There are several ways to approach a RPR, including:

- **A 100 percent review of all claims**, which requires a sizeable investment and a strong IT team
- **A focused review of high-dollar claims.** This type of review can be done by payer or service type or otherwise.
- **A real-time audit of payments conducted online by a third party**

AS YOU CONSIDER WHETHER OR NOT YOUR HOSPITAL WOULD BENEFIT FROM A RPR – AND WHICH APPROACH WOULD BEST MEET YOUR NEEDS AND BUDGET, IT'S IMPORTANT TO ASK AND ANSWER TWO QUESTIONS: HOW MUCH LOW-HANGING FRUIT IS THERE? AND HOW WILLING ARE YOU TO INVEST IN THE RPR PROCESS?

As you consider whether or not your hospital would benefit from a RPR – and which approach would best meet your needs and budget, it's important to ask and answer two questions: How much low-hanging fruit is there? And how willing are you to invest in the RPR process?

Keeping Score

While RPRs can help teach hospitals where they are dropping the ball, scorecards can do the same for managed care providers. For this reason, hospitals should keep scorecards on all of their payers. These documents can tell you, on average:

- What percentage of the claim amount is being paid
- How long it takes for payment to be received
- How often payment is denied
- How this contract is impacting your bottom line

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	1	2	3	4	5	6	7	8	9	10	11	12
CLAIMS PAID	100	100	100	100	100	100	100	100	100	100	100	100
CLAIMS DENIED	0	0	0	0	0	0	0	0	0	0	0	0
PAYMENT PERCENTAGE	100	100	100	100	100	100	100	100	100	100	100	100
...

	1	2	3	4	5	6	7	8	9	10	11	12
CLAIMS PAID	100	100	100	100	100	100	100	100	100	100	100	100
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PAYMENT PERCENTAGE	100	100	100	100	100	100	100	100	100	100	100	100
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Play to Beat the Other Guy's "A" Game

Providing your PFS staff with the training they need to be effective in working with managed care companies will also help drive your hospital's net revenues. Their training should include:

- A lesson in confrontation
- An explanation of their authority. Your PFS staff must have the power to enforce the managed care agreement.
- A crash course on basic contract language
- An explanation of your contract matrix

In turn, have your PFS staff:

- Create a log of problems by payer
- Create a log of denials by payer
- Create a summary of payment variances/tendencies by payer
- Use their knowledge and capabilities to further demonstrate managed care issues, as necessary

Negotiating and Winning: The Basics

When negotiating a managed care contract, **a team approach works best**. This ensures that everyone is on the same page at the same time.

The presence of a **contracting committee** – comprised of your PFS director, your utilization management director and a member of quality assurance – is also critical. This committee must be able to tell you what's going on with a contract at any given time and help you understand the industry norm. These are your resource people.

As you consider a contracting committee, it's also important to decide if your committee will:

- Review trended information by contract – asking, how is it performing?
- Review the administrative manuals and the changes provided by the plans
- Review policy updates from the plans – determining which ones mean something and which ones require action

Finally, a **language/payment checklist** is necessary. Among other things, this document outlines what needs to be in an agreement and what doesn't. It also helps highlight what may be missing from an agreement.

The Strategy

Before you begin your managed care contract negotiations, you should:

- Identify the desired results
- Specify a timeframe for the negotiations
- Define a "walk away" point and/or know when to send a termination letter
- Make sure everyone on your team is on the same page

WHEN NEGOTIATING A MANAGED CARE CONTRACT, A TEAM APPROACH WORKS BEST. THIS ENSURES THAT EVERYONE IS ON THE SAME PAGE AT THE SAME TIME.

In existing contracts, it is also important to understand where the volume is and what contract language may be causing problems.

Due Diligence

To be successful in your negotiations, you must do your due diligence and, ultimately, understand:

- Financial performance. How does this managed care company compare to others?
- Payer performance variation. How do the payers in the group perform? Do most pay on time?
- Scorecard data
- Make-up of the volume:
 - Patient type
 - Outpatient distribution of services
 - Specific services consumed

Reducing Your Risks

The following payment provisions can help you minimize your risk:

- Stop loss provisions
- Minimum payment provisions
- Carve outs for high cost procedures
- Implant and high-cost drugs
- Emergency room payment levels

Reimbursement Killers

These forms of reimbursement create additional risk for the hospital:

- Medicare-based reimbursement for ambulatory surgery centers
- Ungrouped procedures capped
- Percent of charges limited by 1-day per diems
- Chagemaster increase caps
- Unrealistic caps

- Payers failure to respond. Make it their responsibility.
- Define limits of recoupment
- Calculation definition
- Appeal rights
- Invoices required for implants
- Prior notification of stop loss. This requires concurrent coding.
- Anything that requires human intervention

Silent PPO Considerations

To preclude silent PPO activity, include these provisions:

- Minimum steerage
- Other silent PPO constraints
- Identification cards
- Availability of payer listings

Benefit Design Issues

These are critical to know to assess the adequacy of reimbursement.

- Plan design information
- Consumer-driven or catastrophic only coverage

Getting Paid

While state regulations call for prompt payment by managed care providers, it can often prove easy for these companies to wiggle around the rules. For this reason, your hospital should have a policy for prompt payment built into its contract. Ideally, this policy should mirror state initiatives. And if you're not being paid on time, report violations to the Department of Insurance.

Oh, And Don't Forget to Watch Out For...

Evergreen Agreements renew automatically every year, unless someone sends a termination notice. If you have an Evergreen Agreement, you should build an annual increase into your contract, otherwise you'll waste way too much time trying to renegotiate each and every year. If the payer is unwilling to agree to annual increases, don't do an Evergreen Agreement. Rather, do a one-year term agreement.

You should also attempt to avoid unilateral surprises from the payer, such as the adjustment of DRG case weights; the adjustment of fee schedules; and amendments via "Phantom Acceptance."

Next Steps: Always Go Back to the Fundamentals

So, you've negotiated a good deal. Now what?

- Maintain and monitor your matrix so that you always know what's going on with your contracts
- Keep your insurance plan mapping up-to-date. Give yourself an opportunity to make sure it works right
- Put your variance logs to work for you. Make sure you're being paid correctly
- Train your staff

If you have any questions about this white paper, or would like to speak with QHR about your Managed Care challenges, please call Howard Green, director at 1/800-233-1470, ext. 2010. To read more about how QHR has successfully helped clients address managed care issues, go to www.qhr.com, and click on the Consulting Services tab.

