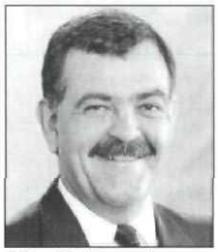
BACK TO BASICS IN MANAGED CARE

Hospitals Need to Rethink the Way They Handle Contracts, Pricing, and Collections

BY DAVID FOSHAGE



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"Can't act. Can't sing. Balding. Can dance a little."
—an MGM executive on Fred Astaire's screen test[1]

"You'll never make it—four groups are out. Go back to Liverpool!"
—a Decca Records executive to the Beatles in 1962[2]

"I don't need bodyguards."
—Jimmy Hoffa in a December 1975 interview[3]

Predicting the future is a risky but necessary activity for developing principles that will carry businesses into the next quarter, the next year, or the next decade. Because such predictions are necessarily inexact, it is critical that they be confirmed, modified, or discarded. Fortunately for MGM, other executives saw the brilliance in Fred Astaire that the above-quoted person did not. Mr. Hoffa's erroneous prediction led to a tragic result.

Over the past six or seven years, predictions regarding managed care focused on capture of enrolled lives. Hospitals, working with physicians, long-term care centers, home health providers, and others, attempted to convert themselves into integrated delivery systems (IDSs), intending to provide cradle-to-grave services on a capitated basis. Many providers did, in fact, enter into capitated contracts, but enrollment levels were generally far below expectations and financial performance was disappointing. Capitation and risk sharing have not grown nearly to the extent anticipated, and most experts now believe that fee-for-service will remain the dominant managed care payment system, at least in the near future.

During the period that saw the growth of IDSs, managed care plans were having difficulties. Operating margins shrank dramatically in the mid- to late 1990s. According to Interstudy, the median profit margin for HMOs declined from 2.4 percent in 1994 to −3.5 percent in both 1997 and 1998 before rebounding somewhat to −1.3 percent in 1999.[4]

Consequently, at the same time that HMOs were sharpening their focus on operational performance, hospitals were distracted by problems associated with building IDSs, primarily losses from employed physician practices. The result has been declining net revenue from managed care plans. That decline has taught health care leaders they need to pay greater attention to factors affecting managed care payments. This article focuses on three key components of this "back-to-basics" approach to managed care: contracting, pricing, and collections.

CONTRACTING

Recently, a regional commercial managed care plan began treating patient transfers from a medical/surgical unit to a rehabilitation unit as a discharge and an admission. By doing so, the plan could calculate the dollar stop-loss thresholds separately for each "stay." Consequently, the threshold was never reached. Because the contract between the plan and the hospital did not define what constituted an admission or a discharge, the cases in question are now the subject of binding arbitration.

This example demonstrates two important points. First, the requirements for getting paid are a moving target. Representatives of the aforesaid plan acknowledged that, in certain cases, they had not followed their newly stated policy, but they dismissed those cases as incorrectly paid. Representatives of the hospital believed that the plan had simply changed its policy to reduce its payments. Second, and more important, the

example demonstrates the importance of a well-constructed contract in avoiding or resolving administrative issues. Although most hospitals carefully review contract terms during initial negotiations, some, unfortunately, neglect to review language provisions in the annual renegotiation process.

The Catholic Managed Care Consortium (CMCC) has published a brochure entitled *Guidelines for Managed Care Agreements* for use by its members. Nonmember hospitals should develop similar guidelines for themselves. These guidelines should prioritize typical contract provisions as either "desirable," "critical," or "absolute." Hospital negotiators should agree in advance about their priorities and then evaluate contracts and contract renewals according to those criteria. If they do not, they are likely to omit critical features because of pressure to complete the contract negotiations.

Hospital negotiators should make sure that the language included in the contract is enforceable. Contract provisions that require payment of clean claims within 30 days of receipt will be useless if the hospital is unable or unwilling to track "time to payment." In CMCC experience, failure to enforce stringent contract provisions is the rule rather than the exception. The lesson here is simple: Rather than abandon these worthwhile contract provisions, hospitals should build the mechanisms to *enforce* them.

Negotiators should make sure that contract language is enforceable.

Pricing

In the early days of managed care contracting, conventional wisdom held that all managed care plans could shift patient volume (that is, move patients from a nonparticipating hospital to a participating one), HMOs more so than Preferred Physician Organizations (PPOs). Consequently, hospitals typically offered HMOs greater pricing concessions than they offered PPOs. As exclusive contracting became less prevalent and new benefit plan designs blurred the distinction between HMOs and PPOs, many hospitals realized that incremental volume (that is, new patients) was less likely and changed their pricing strategy to one that rewarded volume, regardless of product, with more attractive pricing.

Despite this shift in approach, many hospitals continue to find themselves with unsatisfactory managed care rates. "Unsatisfactory" in this case can mean any number of things. A hospital's rate may be unsatisfactory because a large account has dropped out of a managed care plan, thereby reducing the hospital's volume. Or the hospital, having lost an exclusive arrangement with a plan, may have to share the plan's business with a competing hospital, but with no commensurate increase in negotiated rate. Or a plan in which the hospital has equity does not grow despite subsidized pricing by the hospital and its other equity partners. Unfortunately, most rate negotiations between hospitals and managed care plans begin with the existing rate. That being so, a 10 percent increase on an unsatisfactory rate will frequently continue to result in an unsatisfactory rate. To truly improve the rate, hospital negotiators must propose a rate more appropriate than the existing one at the start of negotiations. The question is, of course, what is an appropriate rate? Put another way, what is market price?

True market pricing can only be established by gathering and examining competitor-negotiated managed care rates, which are confidential. However, each hospital has created its own estimate of market prices throughout its universe of managed care contracts. The CMCC offers hospitals a product, called Managed Care Revenue Enhancement, which uses a regression model involving a facility's contract volume and price relationship to calculate a "line of best fit." This line, representing the hospital's internal market price, can be described by an arithmetic equation. By inserting actual plan volume into this equation, one comes up with the rate the hospital can expect, given the leverage used in all other negotiations. In other words, the process produces the number the hospital representatives should use in negotiations.

The CMCC has conducted more than a dozen Managed Care Revenue Enhancement engagements and in them has found a number of common phenomena:

- Negotiated hospital pricing does not appear to approach the point where plans seriously consider terminating the agreement.
- Collections, in a number of instances, are

below variable costs.

- Many small-volume plans pay significantly below negotiated levels.
- Negotiators tend not to reexamine old strategic assumptions; consequently, the rate remains in place even if the assumptions are faulty.

Some hospitals are wary of requesting large rate increases even if they believe that, given increases in volume, they are justified in doing so. They fear that if they ask for increases, the plan will terminate the contracts and the hospitals will lose volume. An increasing number of contracts have been terminated over the last few years, but these terminations have been almost exclusively initiated by the hospitals because of insufficient pricing. Almost no terminations have been initiated by the plans because the negotiated price was too great. Today's environment has given increased leverage to providers, particularly hospitals. In most markets, benefit design and pricing are comparable and provider networks are almost all inclusive. Plan administrators know that they cannot afford to terminate a hospital, thereby creating less marketable provider networks, and therefore do so only with great trepidation. Realizing this, hospitals should be bolder in negotiating with managed care plans.

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Collections

Even with the most hospital-friendly contracting and the most sophisticated pricing algorithm, managed care will be problematic if hospitals cannot collect the amounts owed them. The CMCC has found a number of problems in analyses of hospital managed care processes. Although the problems vary, the common thread concerns lack of useable data to diagnose and correct systemic problems. The two most acute situations concern calculation of expected reimbursement and categorization of denials.

The CMCC has found, in the course of its Managed Care Revenue Enhancement engagements, that only about 10 percent of the hospitals involved have been able to provide reliable expected-reimbursement information. Hospitals are able to specify the amount owed on a particular claim, but cannot do so on an aggregate plan basis. They can determine that CIGNA owes $1,000 for Mr. Smith's claim, for example, but cannot determine with a reasonable level of accuracy what CIGNA should have paid for all its claims over the fiscal year. Hospitals frequently lambaste managed care plans for overaggressive pricing, being slow to pay, or failing to pay at all—but are unable to quantify the problem. Underpayments may be sporadic or epidemic, but hospitals unable to calculate expected reimbursement will not be able to tell the difference.

The second significant problem with collection involves the categorization of denials. Hospitals generally have increasingly decried the rise in denials by managed care plans. But many of those same hospitals are unable to provide the details concerning denials that could help them reduce the denial rate. At a minimum, hospitals should be collecting the following information about denied (including reduced payment) claims:

- Payer
- Physician
- Diagnosis-Related Group (DRG)
- Place of service
- DRG or outpatient classification
- Reason for the denial (e.g., lack of preauthorization)
- Amount denied
- Appeal status
- Final disposition

In the CMCC's experience, traditional denial management has focused retrospectively on dollar recovery. The hospital involved hires a firm to appeal the denials and to collect amounts owed from overturned denials—but neglects to attack the underlying problems causing the denials. The winner in this scenario is the denial recovery firm, which will have a steady client base year after year. A hospital will see a genuine decline in its denial rates only when it begins to collect comprehensive revenue cycle data and address the underlying revenue cycle and clinical issues.

Recommendations

It has become increasingly clear over the past three years that hospitals must sharpen their focus on basic managed care issues. Renewed vigor is required to offset plans' efforts to reduce medical

Continued on page 68

COMPARATIVE DATA

Continued from page 15

again, seeking new insights into mechanisms for change. If it has, the team turns its attention to other areas needing improvement.

Incorporating the "Living Our Promises, Acting On Faith" comparative data by using existing resources and methods, takes advantage of the flexibility and rigor in the current improvement structures and processes and involves more staff in a broader array of areas. In addition, incorporation precludes development of a new structure to address these opportunities for improvement, thereby promoting organizational alignment and integration.

A Call to Action

One of the recurring lessons from "Living Our Promises, Acting On Faith" has been that hospitals that have worked to align their values, mission, strategy, and operating model tend to perform more effectively. And most importantly, they serve their patients better. The data resulting from the project provide a rich, informed description of the current status of the ministry. This information has begun to drive collaborative benchmarking studies at the national level through CHA and at regional levels through individual systems. In turn, these benchmarking studies are beginning to indicate successful practices that can help improve performance across the ministry.

Much more can be done, however, to foster breakthrough improvement within Catholic health care. If each study participant conducted one improvement project over the next year, the collective improvement across the ministry could be astounding. If the entire CHA membership launched one such internal improvement project using the data to help set an improvement goal, the ministry-wide impact would increase three-fold.

When does your improvement project begin? □

BACK TO BASICS IN MANAGED CARE

Continued from page 22

expenses through additional administrative processes. The CMCC has recommended that its members undertake the following strategies as a countervailing force to plan efforts.

Reexamine Traditional Points of Negotiating Leverage Critically evaluate the true potential for plans to terminate hospital contracts. Most hospitals have found that the risk of losing a contract is relatively small and have begun to negotiate accordingly.

Develop a Contract Language Template Make sure that the organization's negotiators agree on and understand the contract's language *before* negotiations start. Too often, poor contract language is the result of perceived pressures to finalize negotiations. The time to make rational decisions about contracting strategy is *not* when $1 million in patient revenue is in play.

Don't Automatically Use the Existing Rate as the Starting Point in Negotiations A 10 percent increase on a crummy rate is still a crummy rate. View managed care contracts as a portfolio, not as individual business arrangements. Understand the relationship between price and volume for the entire portfolio and determine which contracts are underperforming. Make it a priority to improve those contracts to the level at which other contracts are performing.

Develop or Invest in Systems that Measure Your Expected Payments from Managed Care Plans The claims recovery industry has grown out of the difficulties hospitals have had in collecting accurate payments from managed care plans, in combination with hospitals' inability to actually determine the amounts owed. Without resolving underlying claim denial or underpayment issues, claims audits can become an annual event. Hospitals should develop and staff efforts designed to accurately calculate expected reimbursement and collect all monies owed at the time the claims are paid.

Manage Claim Denials The Health Care Advisory Board reports that the percentage of Maryland hospital claims denied increased from 3 percent in 1996 to 6 percent in 1997 and 9 percent in 1998.[5] As the number of denials and the dollars denied continue to increase, hospitals must begin to understand the reasons for denials and take corrective action. Until they begin understanding basic information—such as that involving a claim's attending physician, DRG, place of service, and denial category—hospitals will find it impossible to correct the problem in a systematic way.

Even successful managed care departments will be under continuing pressure from both senior managers (who require contracts to be profitable) and managed care plans administrators (who want to reduce expenditures). To satisfy management and resist plan administrators, managed care departments require a back-to-basics approach that aggressively manages solidly drafted contracts, negotiating appropriate rates, and collecting all monies owed. □

NOTES

1. Ross and Kathryn Petras, *The 776 Even Stupider Things Ever Said*, HarperCollins, New York City, 1994, p. 21.
2. Ross and Kathryn Petras, *The 776 Stupidest Things Ever Said*, HarperCollins, New York City, 1993, p. 156.
3. Petras and Petras, *The 776 Even Stupider Things Ever Said*, p. 11.
4. InterStudy, "HMO Industry Report," *The Competitive Edge*, 11.2 Edition, January 1, 2001, p. 52 (see www.hmodata.com).
5. Health Care Advisory Board, *The Commanding Heights*, p. 44 (see www.advisory-hcab.com/public/about/brief/the_company.asp).