Are You Optimizing Your Contract Performance Data?

Today's healthcare providers face increasingly complex payer rules that need to be interpreted and applied during patient scheduling and registration, case management, and billing processes to ensure accurate payment and protect cash flow. As a result, healthcare financial executives occasionally may feel overwhelmed when it comes to understanding and managing contract performance. In this HFMA Executive Roundtable, sponsored by Concuity, participants discuss strategies for optimally using performance data to implement change and improve payer compliance.

What metrics are most useful to track for contract performance? Which ones are best used in executive reporting?

Karen Mihalik: We use our contract management tool to examine underpaid claims, identify the root cause of those issues, and track resolutions. At a higher level, we publish information at the payer level related to days revenue outstanding, payment aging, analysis of accounts receivable, and aged A/R [accounts receivable]. This year we've also started looking at trends in patient liability, not just to look at how much is being shifted to the patient, but what is the collectability of those balances. We can track whether they end up as bad debt or charity care.

David Rodriguez: Some useful metrics at the director or CFO level are gross A/R days, unbilled A/R days, cash as a percentage of gross revenue, bad debt expense, charity care, and net billed to revenue received.

At the director or management level, it's all the things the executive is looking at, but also you want to really start to understand denials by source. For example, what are some of the preventable denials versus the non-preventable underpayments and denials? Also, examination will often include bad debt by service location and by service. At the management-staff level, the most useful data are all of the things just listed plus data to help with finding where the issues are. It's really important for these staff to be able to get down to specific accounts to understand what's going on. Can we identify trends? Can we identify certain anomalies that might link back to the contract or the payer?

Suzanne Daly: There's not really a single metric that we would use. Rather, it's more of a process. We use a software tool whereby an analyst takes our payment terms and loads them into a calculation engine. We then take claims for a specific time period and will run them through these calculations. The result is an estimate of net revenue that would be paid under the payment terms. This helps inform our contract negotiations by identifying whether the contract is likely to yield the result we're hoping for.

Once we're done negotiating, our analysts activate the rates with the software system. Then payments, at a claims level, are run through the calculation engine. When a payment doesn't match what the engine calculates, it is flagged for a coordinator. The coordinator then validates and corrects the payment error.

When monitoring contract performance, we look at denial rates and denial resolution. If we see a really high percentage of both, then that's a problem because it means we're spending a lot of time pursuing payment on things we ultimately get paid on anyway. We have total outstanding A/R dollars, number of days in A/R, and the percentage of

the dollars over 90 days. These measures tend to reflect whether payers are paying the small-dollar claims quickly but holding onto the large-dollar ones. We also look at factors relating to electronic remittance, examining whether we are being paid electronically for everything we are owed. We also consider the quality of a payer's web site in terms of whether we are able to validate eligibility and benefit coverage levels easily.

David Livingston: We've just started working on monitoring some of the qualitative measures with our PFS [patient financial services] and case management staffs. We're going to start doing a quarterly survey to find out how easy it is to work with the payers. When a payer is continually difficult to communicate with, then we need to put in contractual language that ensures that we have certain levels of service.

Gibbons: To track financial performance of a contract, you need a depository database that is detailed enough to identify and track occurrence by the type of denial—for example, whether it is something as simple as an administrative denial or whether it is more complex, such as a clinical denial.

One thing I've found helpful is to always have a coding sheet for the case management or billing department to use when they enter data into this database. That way, everybody is consistent in terminology. Also, it is important to include the reasons why the claim was denied. Each reason—a lack of medical necessity, proper authorization, or clear documentation—will tell a different story and a different corrective action that needs to take place.

Participants in this HFMA Roundtable:

Suzanne Daly is senior director of contracting and reimbursement services in the Montana and Washington region for Providence Health Systems.

Kati Gibbons, FHFMA, is director for reimbursement and financial planning at St. Luke's Hospital and Health Network, Bethlehem, Pa.

David Livingston, FHFMA, is vice president, payer strategies and contracting, at Trinity Health, Novi, Mich.

Karen Mihalik is senior director, patient financial services-financial reporting and analysis, at the Cleveland (Ohio) Clinic.

David Rodriguez is director of sales and product marketing for Concuity, Vernon Hills, Ill.

How often are the data reported and to whom?

Rodriguez: At the CFO level, monthly reporting prior to the accounting period close typically is best. This way, the CFO can look at sources of leakage, trends going on with the cash, and any issues that will help forecast what's going to be coming in the next month. Weekly or daily reporting is better suited for people in the day-to-day processes, depending on their role. A staff manager will want to see the data daily because doing so is needed to effectively work the accounts. A director will need to see progress weekly to monitor that manager's performance.

Daly: We rely on three types of report cards. The first is an annual external report that goes to payers. It features a letter grade for various performance metrics, such as payment timeliness and accuracy, denial rates, and ease of use. Our goal is to work collaboratively with payers on initiatives to improve performance. There is also an internal version of this report card that arrays all payers and is distributed to clinic and hospital leadership as well as the revenue cycle leadership.

Our second type of report card is distributed internally each month and focuses on payment accuracy. It highlights amounts collected due to underpayments from each payer and includes the reasons for the underpayment—which allows us to work through root-cause analysis. This report is distributed to finance leadership for each hospital and to the contracting team.

The third report card is distributed monthly by decision support. It shows monthly and year-to-date trends in revenue and cost by service line, payer, and any other way you might want to slice the data. These reports allow us to monitor cost and financial performance by type of service and by payer. For contracting purposes, we can use this information to correct funding in a specific area, or we can also see if a payer is particularly good at helping us lower costs—for example, through length of stay management, employed hospitalists, or other initiatives.

Livingston: We're developing our executive dashboard, which will be provided to our senior leaders. Because looking at a single point doesn't always provide the whole story, we're really going to focus on trends. The metrics that will

probably be of most interest are contract profitability and overall denial rates. If we have payers that have dominant positions within a market and in the payer mix, it makes sense to provide details on them and aggregate the smaller payers.

What advice do you have for identifying a contract performance problem and alerting others?

Mihalik: Within PFS, we handle the day-to-day operation of dealing with underpayments and addressing root causes to try to get those claims paid. However, when we identify a significant trend, a slowdown in resolution, or an issue that requires further escalation, we initiate a process for alerting others. We seek input from our managed care team and then, as needed, work at an escalated level with the payer to resolve the issue. If it is a significant enough issue, we also will engage our PFS leadership and CFO.

Daly: It's really a matter of being disciplined in producing the metrics and in using the metrics to inform decisions. We strive to improve what we measure and to take the metrics seriously, escalating attention the first time a number exceeds its "acceptable" level. This sounds pretty basic, but given the complexities of our healthcare system, such basics often get lost. It's easy to lose track of a particular issue for several months and fail to recognize the trend. It can then take another two to three months to get the intervention implemented and another few months before you see the results. Something as simple as managing your days in A/R can be key. As soon as you see a spike in a month, then you can say to the payer: "I noticed A/R days have gone up by 10 percent. What might be the cause? Did you have a system issue?"

Livingston: Timeliness is important. As soon as we see signs that we're going in the wrong direction, we quickly drill down, identify the issue, and try to work with all of the parties on a solution. We had an issue earlier this year where one payer was consistently processing a particular claim type incorrectly. We reached out to the payer right away and walked through what the issue was. The payer understood that its system was configured incorrectly. So we were able to resolve this problem promptly and eliminate the need for a lot of rework on our part and the payer's part.

How do you prioritize contract analysis efforts?

Mihalik: It's a combination of dollars and volume. Sometimes an individual claim may warrant immediate follow up, or we may have a smaller-dollar variance affecting 5,000 claims that warrants equal or even greater attention. Being able to sort through that volume and understand what to work first is an art, not a science.

Daly: We focus on our larger commerical payers and on Medicare and Medicaid. These seven to 10 payers make up about 90 percent of our total revenue. We also focus on specific service lines that are underperforming or need remediation as well as specific payment terms that have a high frequency of being administered incorrectly.

Where is technology, such as real-time reporting, offering new opportunity?

Rodriguez: Web-based technology is where things are moving. The data are easy to access and distribute quickly to others in the organization so they can best determine how to help. This enables a management-level person to be able to go to the CFO at any given time and say, "You asked me for this report, and I can give it to you by the end of the day." That's powerful.

It's also important to note that many hospitals' patient accounting systems have very limited capabilities for contract management, accurately netting down A/R, performing follow up, and reporting. Payers typically have this information, which leads to a tremendous advantage

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for them going into negotiations. Technology can help providers so at the push of the button they can have all of this information and are able to give it to their managed care department to help them renegotiate.

Livingston: A lot of these real-time reporting applications are starting to become more available. It's very exciting. It will allow us to be more proactive in identifying trends. However, a balance needs to be maintained between reacting just because the data are available and being able to identify what the real issues and trends are. If I had information that popped up every day, I could get bogged down in just responding to that and missing the big picture. Having faster reporting is valuable, but we need to make sure we can actually act on the information.

How do you use data to implement process change and improve compliance?

Mihalik: We distribute our denial inventory to get it into the hands of the person with the best ability to fix the account. That person can also help to put tools in place to prevent the next denial by understanding the root cause of the issue. For example, our coding and medical necessity denials are addressed by nurse reviewers and/or coding experts, while the billing staff works the simple documentation requests. We also have tracking tools in place to identify whether accounts are being worked on a timely basis and trends by payer. We track whether accounts are paid or need to be written off.

Gibbons: For payers, it's important to start by going to the first-line contact, showing the data, and asking for help in correcting the issue. Also, the payer needs to understand that you're confident in your findings. Some may respond by saying that you're right, and the claims need to be processed and paid. You're going to work with that payer. For others who dismiss the data findings, you may have to flex some muscle. Should you find a payer dragging its feet and not wanting to do the right thing, then you may have to consider a more formidable step. Some contracts have arbitration clauses in them or you may need to consider the need to get out of the contract.

Daly: We have a really consolidated payer market. Seventy-five percent of our commercial patients come from four payers. Our interest is to ensure we are not a barrier to the insurance marketing by being innovative and competitive. We have implemented contracting principles that support payment parity. Price advantages are driven by cost savings, and price disadvantages are driven by negative cost impact. We want to pass through savings to companies that invest in cost-reduction initiatives. We also want to pass on higher costs that might be associated with companies that increase our cost of doing business with them. In effect, if we experience a lower cost to collect because of few denials or faster payment, then we recognize this value in the rates. And the opposite is true as well; if we have to add another collector to manage our contract compliance function because there are a lot of payment errors, then that is going to be recognized as a price disadvantage in our contracting. The approach is intended to encourage collaboration with payers. In addition to moving to pay for performance in regard to clinical outcomes, we can mirror the principle by offering higher discounts for improved financial outcomes.

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