Reform-related regulatory changes are bringing greater complexity to the payment landscape, including shifts in coverage. Faced with these changes, hospitals need to intensify their strategies to ensure that valid healthcare claims are paid accurately, quickly, and efficiently. With this in mind, this HFMA Executive Roundtable, sponsored by Emdeon, explores ways healthcare executives are using process change and technology to support contract adherence and payment integrity.

**How does your organization monitor payer performance?**

**Philip Hardin:** Monitoring should be done in two ways: One is by claim in real time, so you are able to follow up on issues and resolve them immediately. Second is monthly and quarterly reports to assess your overall control of the process and to follow up with payers on overall issues.

**Julie Tipps:** We do an annual satisfaction survey of about 500 employees who work with managed care payers on registration, billing, care coordination, or collections. We use this information to detect and track process issues, such as problems with eligibility, authorizations, mistaken denials, and discharge planning, and we measure the administrative cost per claim filed. The results of this survey are shared with payers annually. The other half of the report card is ongoing financial analysis, which includes administrative costs of billing and collecting per case, dollars tied up in clinical denials, and late payments and underpayments as a percentage of cases and as a percentage of net revenue.

Because the information is used to improve performance, and not to be punitive, the report card is “blinded” meaning no payers names are used. In addition, we meet with payers monthly or quarterly to review performance. FY09 was the first year we appealed outpatient denials, which resulted in $3.7 million in recoveries. In all, more than $10 million of the $12 million denied by all payers was recovered on appeal.

**Jason Adams:** At MultiCare, we share a structured scorecard with payers in hopes it sparks competition to improve their operations. We monitor denied claims, A/R turnaround time, and the quantity of denied claims that have been overturned. For the past three years, we have met monthly with our top 10 commercial payers, who make up about 95 percent of our commercial revenues. We have seen A/R days drop by about four to five days over the past couple of years. This improvement has had significant effect on cash flow; a day amounts to about $10 million for us.

**Lyman Sornberger:** We have a paper scorecard with 26 metrics that we share with payers, as well as the costs of doing business. These monthly payer scorecards are presented internally at the enterprise, facility, technical, and professional level. This dashboard shares with the payers all of the metrics that Cleveland Clinic uses to measure ourselves internally, including days in A/R, denials management, payment floor, and aging. The scorecard is shared with the payer in context of the payer’s market competitors with data from other payers blinded. Our intent is not to present the “report card” as a punitive measure. We want to provide the information so we can work together to improve performance and save costs for both parties. In addition, we survey our staff and the payers annually at the payer level and share the results with the payer and health system.

**David Wurcel:** We model every claim and perform a detailed review of variances between the estimated contractual amount owed and the amount paid. Variances are tagged for daily review by our patient account analysis team. We then use root cause analysis to determine the true cause of variance. Such efforts give us detailed information that we can use to address issues in our
own processes and with insurers. When we go to the insurer, we can be very clear on what we need.

The efforts are paying off. Our entire denial issue is in the 1 percent range, and we are sitting in the mid- to high-30s on days in A/R. Such performance is all due to having good, productive relationships with our payers.

What metrics do you find most useful to track, and how often?

**Tipps:** Late payments and underpayments are most useful to track because insurers are contractually bound to pay accurately and on time. All of the contract provisions for every contract are loaded in our system and tracked automatically, and we receive daily reports. We also examine cost to collect and the administrative time to process claims that didn’t pay correctly. Many payers have added extra processes at the front end of the revenue cycle—pre-certifications, pre-authorizations, and 24-hour notifications—so it is important to measure these things to understand the added cost.

Also, comparing payer performance is particularly important. There is a big difference among payers. When you bring this difference to their attention, some of them really improve.

**Adams:** Denied claims, A/R turnaround time, and denial overturn rates are among the most important metrics to track. We look at the quantity of denied claims and the number that are overturned, so we can identify edits that do not seem useful. If a payer is denying 100 claims and 98 of them are overturned, then clearly we need to look at the process so both parties aren’t wasting effort. We have been able to correct some edits this way as well as reduce accounts aging past 90 days. Also, there has been a reduction in denials and requests for additional information.

How is payer performance best communicated?

**Tipps:** We communicate through report cards and monthly meetings with individual payers where department people from both organizations meet face to face. Developing relationships this way between people who talk with each other every day really helps.

The focus of these meetings is working together to improve processes. We have our information in hand and we talk about the payer’s issues, too, so we can identify solutions that are acceptable for both of us. Also, these meetings are very data driven. We show up with spreadsheets depicting specific trends. No one wants to waste time with opinion; people want to see examples.

**Adams:** The goal is performance accountability. So you need to set clear expectations and deadlines, and communicate at the appropriate level in the payer organization. It’s important to recognize that it is beyond the account rep’s ability to change operations. When you have an operational issue, you need to talk to someone in the organization who can effect change. When we request that someone at this level participate in our meetings, payers tend to be very cooperative.

**Wurcel:** Where the relationship used to be a two-party arrangement between the people who billed and the people who paid, it is now a four-party system: The hospital and payer also have contracting departments. Input from these contracting departments is particularly important because everyone has to live by the agreed-upon terms.

With this in mind, we bring all parties together on a regular basis so they can understand and communicate with each other. Additional meetings are scheduled with utilization management teams as denial rates dictate.

What can you do to address inadequate payer performance, such as excessive underpayments or mistaken denials?

**Tipps:** We have a dedicated denial resource center staffed with nurses and clinical representatives. They are versed in the relevant issues; it’s not like someone who is trying to manage these functions on top of regular collection duties. The resource center staff get every claim that has a denial and prioritize it by time and dollar amount. We have an 89 percent denial overturn rate for inpatient claims. We also have a dedicated contract compliance unit that handles underpayments and other issues that have not been resolved through normal collection efforts. They have special training in contract interpretation and
work directly with our managed care payers regarding contract issues, interpretation, and enforcement.

**Wurcel:** If we feel like we’ve done everything we can for resolution and a denial or underpayment is still on the issue list after six months, I will escalate the matter to a managed care senior vice president. Such action isn’t taken lightly. I don’t want to discuss it with an SVP until I’m certain all administrative and clinical review processes have been exhausted. When I do have to speak with an SVP, I’ll say, “No one is right or wrong, but we have a contractual legal issue that is at an impasse, and it is time for a decision.” If discussions at the SVP level don’t bring resolution, then we will issue a notice of violation. But such action happens very seldom.

**Sornberger:** We provide feedback on a regular basis to our payers. Our meeting frequency varies based on current contracting timing and performance issues by either party. We also will address inadequate performance in contractual negotiations. Finally, we have worked with payers and continue to collaborate through various project alignments. These meetings are more strategic in nature and both parties strive to improve the metrics and decrease the cost of doing business. The outcome is a host of metrics that we agree the two entities will use to measure the success of the collaborative effort.

**How do you prioritize among performance issues?**

**Hardin:** The first priority is to ensure that you are collecting to the contract provisions, focusing on high-dollar claims and on high-frequency, low-dollar issues that create substantial revenue leakage. Then identify process issues that contribute to leakage in access, chargemaster, and contract management, and be prepared with the facts to have an effective dialogue with payers.

**Sornberger:** We look at controllable losses and behavior issues. For example, some payers require you to report admissions within 24 hours, but they don’t have staff available on weekends. What often happens then is that we will call the admission in, but it doesn’t get processed by them until Monday. Then they deny the claim because we didn’t get approval in time. In these types of instances, we’ll say, “This contract and behavior does not support the clinical and financial needs of our operation.”

Payers know we will not let underpayments slide, so they work with us. Even if it is only $1 that is underpaid for a chest X-ray, it can easily amount to $80,000 in a large system such as ours. Often we can afford to put someone on it, whereas a smaller hospital or physician’s office might find the staff effort not worth the amount at stake. The key here for any size organization is that for small-dollar issues you cannot resolve one-by-one, you should create a process to aggregate them so you can address them as part of your regular meetings.

**Wurcel:** We deal with overpayments, underpayments, rejections, and denials in different ways. Most important, we try to match the problem with the skill set. We recognize that an issue involving authorization will likely require a different type of skill to resolve than, say, an issue involving whether a particular service is covered by the insurer. Someone with greater clinical and/or contract knowledge will be needed to manage a coverage issue, which often requires sophisticated understanding of medical necessity or differences in contract interpretation.

Also helpful is that we took the entire variance group offline, and created a receivable class that is still in A/R but is separate from the regular follow-up and billing cycle. Working variances may require specialized skills to determine and rectify the source of a problem where the normal A/R cycle follows established procedures. With this process, we identify payer issue trends sooner and more efficiently.

**Are there areas where technology is offering new opportunities for payer performance monitoring?**

**Wurcel:** Electronic medical records allow us to work with payers on reducing denials through faster submission of patient data. Also, use of user-defined screens in our billing system has allowed us to tag accounts and subsequently collect better data for monthly reporting. One of our larger challenges, however, is detecting changes in carrier policy manuals that deviate from the contract.
For example, a carrier may pay for drug X at $10,000 a dose and then adopt a policy whereby the provider must first try drug Y at $50 a dose, so all of a sudden you get rejections or variances. Although carriers inform providers through bulletins, the information tends to be too little, too late. You need support for constant monitoring.

**Hardin:** Contract management is often used by providers mostly for rate modeling and negotiation. It tends to be much less integrated with the charge management, claims management, and denial management. When providers lack the capability to identify contract variances accurately, they end up limiting themselves to focus on a few high variances only because they don’t have the ability to detect wider leakage. Integrating contract management allows you to review all claims to identify variances so they can be worked on a timely basis and pursued by those with the appropriate skill set.

**Adams:** Our biggest success has been focusing on payment validation. We run every account through contract modeling to get an estimated payment amount and then we work from exceptions for any variance above or below a threshold. We have a team of five FTEs dedicated to variances. We were losing more than $10 million annually, and we would still be losing that much without it. One insurer denied almost every claim for an MRI with contrast. We would have an approval for an MRI, but the clinician would decide they needed a contrast agent. We were able to get the carrier to loosen the requirements for authorizing MRI with contrast to get those claims paid.

**Sornberger:** With one payer we had about 60 percent of our denials approved on appeal. We looked at appeals they had approved and determined together that it cost about $26 to rework a claim. We were able to eliminate most of the denials, and it has reduced costs by about $1 million per month for both parties. The payer hasn’t reneged. I kept watch and the scorecard hasn’t been red for eight months.

**Hardin:** At a 600-bed government trauma center that had difficulty managing complex workers compensation payments, we were able to load, model, and audit the schedule to determine there was a variance. We developed a training program for the hospital’s management team to correctly calculate the payments. Recoveries were $2.5 million, and we are monitoring periodically. When the issue reappears, we recommend retraining.

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**What advice would you offer providers looking to successfully communicate contract performance with payers?**

**Adams:** Set an agreed-upon metric and agree to a consistent time for meeting with payers. Establish baseline key metrics around days in A/R, denials, and process encounters. And be transparent with your data. By doing these things, payers will know you are not hiding anything, are acting with integrity, and are giving them sound information.

**Sornberger:** Look at the whole picture. You should know not only how much you are getting, but also how much it is costing you to get it. Also, think about what A/R management means to the patient. My worst day is a patient complaining to the boss that he or she is caught in the middle between the clinic and the payer. It’s not just because I am in trouble with my boss, but because I recognize it jeopardizes service excellence and our mission of “Patients First.” There is a cost to both provider and payer when we put the patient in the middle.