

# Getting the Most from Your Payor Contracts

Strategies for Improved Negotiations and Enhanced Patient Collections

BY TOM STAMPIGLIA



In a practice environment characterized by declining reimbursement and rising operational costs, effective management of the revenue cycle is more important than ever. A growing number of physician groups have made payor contract performance a major focus of their efforts to gain control of the revenue cycle. Considering that payor contracts determine reimbursement for services rendered and drive practice revenue, it should come as no surprise that this approach has yielded positive results.

In fact, contract management systems have proven to be very effective at helping physician groups recover revenue that would have otherwise

been lost to claim underpayments and denials. But, while these systems are recognized for their effectiveness in helping practices identify and appeal underpayments, they are less well-known for their positive effect on other, equally important revenue cycle issues such as contract negotiation and patient collections.

Contract management systems value medical claims based on the complex terms of today's healthcare contracts, including carve-outs, global fee periods, multiple surgery reductions, modifier multipliers, code edits, and site-of-service payment adjustments, to name a few. By using this information and comparing it to the latest contract terms, physi-

cian groups can not only identify and recover underpayments but also correct front- and back-office errors, negotiate better contracts, make chargemaster adjustments, and reduce patient write-offs.

Once a physician group's contracts have been loaded into the system, staff members can efficiently value claims and flag potential coding issues prior to submission to the payor. This step helps increase clean claims rates, reduce days in accounts receivable, and minimize the costs of reworking underpaid or denied claims.

When a payment variance is identified, the system provides a contract-based, detailed explanation for each claim, giving providers the necessary data to make the appeal. Both individual and batch appeals can be made efficiently, streamlining the process and improving the practice's bottom line. Payment variances may also represent registration or posting errors, which can be costly to the practice in many ways.

Such systems also provide comprehensive reporting capabilities, giving practices the ability to look retrospectively at contract performance, assess the implications of proposed contracts, and negotiate more-favorable terms.

## Leveraging Contract Data in Payor Negotiation

In most industries, when businesses sign a contract, they can quickly and accurately project the revenue implications. This is not the case in health care, as physician groups are all too aware. Payor

contracts are rarely this straightforward, and virtually all physician groups have had the experience of signing what they thought was a good contract, only to discover it deeply discounted reimbursement for a frequently performed procedure.

With today's complex medical services agreements, practices face a steep challenge in accurately predicting how new contracts and renewals will affect reimbursement for the specific set of services they offer. In addition, once contracts are signed, providers are at a disadvantage in monitoring actual contract performance against expectations unless they have an effective contract management system in place.

Contract analysis modules, which leverage the data that a group's contract management system accumulates during the course of claims valuation, have emerged as valuable applications for improving negotiations and monitoring overall payor compliance. By applying contracts under consideration to historical claims data, practices can accurately and quickly determine the true financial impact of proposed contracts and renewals for their service mix. The key benefit for physician groups is that they are armed with the information they need to strengthen their negotiating position with payors, which can result in more-favorable contract terms and increased revenues.

When providers have access to data that offer an accurate picture of contract performance, they can negotiate with a focus on the factors that most affect their reimbursement. Contract analysis tools allow practices to use their own historical data to generate "what if" analyses that show precisely how new contracts will perform. By applying proposed terms to the mix of services provided, a physician group has all of the knowledge it needs to make informed business decisions. In other words, practices can analyze their specific historical claims data to determine the actual impact of proposed

contract terms rather than having to take payor projections on faith.

## Practices face a steep challenge in accurately predicting how new contracts and renewals will affect reimbursement for the specific set of services they offer.

From the provider's perspective, it is important to consider past contract administration costs in addition to reimbursement rates. Workflow tracking tools provide a reporting mechanism to demonstrate each payor's rate of contractual payment errors and the average number of days taken to settle claims. When payors underperform in these areas, they increase a physician group's administrative costs, making error rate and speed of settlement important negotiating points.

UT Medical Group, a 325-physician, multispecialty practice in Memphis, Tennessee, has been successful at eliminating the unpleasant surprises that can accompany new and renewed contracts. After implementing a contract analysis module, the practice began producing customized reports that accurately document the reimbursement levels and contract performance for each payor. The information UT Medical Group has derived from analyzing contract performance data has strengthened its position during payor negotiations.

A contract analysis module provides UT Medical Group with the information it needs to negotiate improved rates on an individual CPT code basis. For instance, during negotiations, one of the group's largest payors was adamant that the practice was being offered a substantial increase. By using its contract management system, however, UT Medical Group knew that its prac-

tice pattern had changed. The group was able to conclusively demonstrate that the payor's proposal would result in a decrease in reimbursement based on the codes the medical group actually bills to the payor. The "what-if" approach to contract analysis provided the practice with the information necessary to avoid a costly mistake, and helped their team negotiate a more favorable, better-performing contract.

### Time-of-Service Estimates

Providing patients with accurate, easily generated payment estimates at the time of service is another major challenge for many practices. Lack of information about how much payors will allow for each procedure is typically the biggest obstacle to accurately predicting patient responsibility for fees. Without knowledge of these allowances, it is virtually impossible to estimate patient fees, let alone collect them before services are performed.

Although it is true that practice staff can offer time-of-service cost estimates, these estimates are usually calculated painstakingly by hand, and require manual research as well as phone calls to the patient's health plan. For that reason, patient estimates are usually limited to high-value encounters.

With the right technology, however, practices can better serve their patients. The need for time-of-service estimates is certainly compelling. As a percentage of total healthcare spending, out-of-pocket fees have been rising substantially. The growing popularity of consumer-directed health plans (CDHPs) as well as higher copays and deductibles in traditional plans are among the trends associated with increased out-of-pocket patient fees.

The growing onus on patients makes it more important than ever for practices to help their patients make smart, informed healthcare decisions. Groups that provide their patients with accurate time-of-service estimates and financial

counseling help them do just that. As an added benefit, these practices can increase revenues and lower administrative costs.

The growing onus on patients makes it more important than ever for practices to help their patients make smart, informed healthcare decisions.

The sheer number and variety of health plans in today's reimbursement climate can make it quite challenging for healthcare providers to determine the patient's portion of the fee at the time of service. For this reason, many practices hold off sending bills to patients until payor reimbursements are received. Yet, waiting until after the service is performed to bill patients delays payment and can lead to an endless cycle of billing and collections, complicated by patient misunderstanding over exactly how much he or she owes. In addition, satisfaction can be negatively impacted when patients feel resentment upon receiving unexpected—and, often, unexpectedly high—bills.

Austin, Texas-based Texas Orthopedic Sports & Rehabilitation Associates (TOSRA) is one practice that recognized an opportunity to refine and improve the way it provided patient estimates. In 2005, TOSRA added a module to its contract management system that produces patient estimates for upcoming procedures. With this module, staff simply key in the CPT code(s) for the procedure, allowing them to quickly determine allowances based on the latest contract terms. Then, by taking into account the patient's coinsurance and deductible, as well as the group's collection policies, TOSRA can determine the patient's financial responsibility.

The group deployed an estimating tool primarily to enhance its

services to patients, but also as a means of increasing time-of-service collections. Now, because treatment costs are discussed before services are rendered, patients have clear expectations of what they are liable for and what the insurance company will cover. Since February 2005, when it began offering automated price estimates, TOSRA has seen its patient volume remain strong and customer satisfaction levels improve. More than 95 percent of patients report enhanced satisfaction as a result of time-of-service estimates, citing an improved knowledge of procedures, clear understanding of financial responsibility, and an ability to make informed decisions regarding procedures.

With 4,000 claims flowing through the practice per month, TOSRA identified cash flow improvement as another objective of the estimating module. The tool has exceeded expectations. Prior to deployment, only 30 percent of patients paid estimated copayments and deductibles; now, 90 percent of patients pay their fees. In addition, bad-debt late collections have decreased by 64 percent. This represents a significant saving, especially considering that administrative costs for each patient statement amount to six dollars in staff time and handling. TOSRA has also minimized the cost of carrying patient accounts. In fact, patient balances have improved significantly to an average of 30 days in accounts receivable, and patient collections have risen by 45 percent.

### Mastering Contract Complexity

As profit margins for many physician groups decline, a growing number of practices are looking for ways to take charge of the revenue cycle and manage it more effectively. Systematic claims underpayment and denials are well-known contract performance issues, but the story doesn't end there. Contract negotiation and effective collection of patient fees are additional areas in which contract management systems can help physi-

cian groups improve their processes and increase revenues.

In short, it is no longer necessary for physician groups to write off underperforming contracts as a cost of doing business. Payor contracts will continue to be complex, and they will continue to change frequently. But by employing the right methods to master payor contracts, many practices are now managing the revenue cycle in a manner that yields increased revenue, improved workflow efficiency, and increased patient satisfaction.

*Tom Stampiglia is CEO of Austin, Texas-based Medical Present Value, Inc. (MPV), a provider of financial tools and services to help medical groups manage payor contracts and audit reimbursement. [www.mpv.com](http://www.mpv.com)*