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Stop money leaks and boost reimbursements for your community hospital or health system

3 critical areas of focus to directly improve your bottom line

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Reading time, 15 minutes.

Summary

We examine the top challenges faced by CFOs of community hospitals: ***more adverse payer strategies than are faced by large health systems; changing Medicare and Medicaid rules; and administrative work draining physician and executive resources***.

The key to stopping money leaks and increasing reimbursements and profit margins in your organization lies in maximizing cash flow while improving your payment terms.

The critical areas of focus required to meet these challenges include ***optimizing payer contracts through review and negotiation; strategically managing payers through selection, compliance and communication; and building market share through direct contracts with self-funded employers***.

You've worked hard to maintain your independence. While hospitals your size are being swallowed up by bigger health systems, you've stood your ground in order to continue serving the communities you know desperately need your services.

As a critical access hospital, health system, physician practice, safety net provider or integrated provider network, you deal with the same challenges as larger hospitals—while having to survive on lower margins. (Key word, survive: 93 rural hospitals have closed in North Carolina alone over the last 8 years.)

There are three critical areas that, when improved, can make or break a health system's profitability. Before we talk about solutions, however, let's get clear on the issues you face on a day-to-day basis.

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>
> *Deborah J. Bowen, FACHE, CAE, president and CEO of ACHE*

Financial Challenges	ALL RESPONDENTS
Increasing costs for staff, supplies, etc.	70%
Medicaid reimbursement (including adequacy and timeliness of payment, etc.)	68%
Reducing Operating Costs	59%
Bad debt (including uncollectable emergency department and other charges)	56%
Competition from other providers (of any type–inpatient, outpatient, ambulatory care, diagnostic, retail, etc.)	50%
Managed care and other commercial insurance payments	50%
Medicare reimbursement (including adequacy and timeliness of payments, etc.)	49%
Government funding cuts (other than reduced reimbursement for Medicaid or Medicare)	48%
Transition from volume to value	48%
Revenue cycle management (converting charges to cash)	43%
Inadequate funding for capital improvements	37%
Emergency department overuse	31%
Moving away from fee-for-service	30%
Pricing and price transparency	29%

Figure 1. ACHE survey results polling CEOs of community hospitals for their top financial issues

Top challenges faced by CFOs of community hospitals

Financial concerns head the list of community hospital executives' primary concerns, according to the American College of Healthcare Executives' annual survey of top issues confronting hospitals.[2] Government mandates and patient safety and quality tied for second, while staff shortages ranked third. These major concerns have remained unchanged since 2015.[3]

Of those financial challenges, over half of respondents pointed to reimbursements as a major factor, including adequacy and timeliness of payments from managed care and other commercial insurance (50%), Medicaid (68%), and Medicare (49%).

"Leaders are working to overcome challenges of balancing limited reimbursements against the rising costs of attracting and retaining talented staff to provide that care, among other things," explains Deborah J. Bowen, FACHE, CAE, president and CEO of ACHE.

Two of the biggest financial challenges named by CEOs—namely, increasing costs for staff, supplies, etc. (70%) and reducing operating costs (59%)[4]—can also be mitigated by increased reimbursements and recaptured revenue that is currently being lost to limited, inaccurate or late payments.

CHALLENGE 1

Here are three challenges identified by health system executives as having the most critical impact on their organization's revenue cycle and bottom line:

More adverse payer strategies

Hospitals and health systems face an increasingly intense payment environment. "Payers are creating more roadblocks to either limit or slow the pace of reimbursement, while patients strive to cover their costs and staff turnover subverts process improvement," Julie Auton of HealthLeaders writes.

As health costs accelerate, with new technologies and pharmaceuticals entering the market, hospitals and payers are put in competition to see who will assume the associated risk.

"The cost to provide care to patients goes up year after year, but we're not seeing an increase in reimbursement. Instead, we're fighting daily to get the reimbursement we are due," says Abby Abongwa, vice president of revenue cycle at UW Health in Madison, Wisconsin. "The payers are looking for opportunities to change the policy or find mistakes, but ultimately are trying to pay at a lesser amount than we would expect to be reimbursed."

Well-capitalized payers have access to resources and knowledge that can eclipse small, independent health systems. At the same time, payers benefit from the same delays and deficiencies in revenue cycle that can push a community hospital toward closing its doors. Health systems need a way to level the playing field.

An external managed care partner can help balance the scales, speeding your revenue cycle by providing the systems, processes and expertise to leverage payer contract negotiations and fulfillment, as well as ongoing communications and auditing to eliminate payer errors and increase your reimbursements.

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CHALLENGE

2

Changing rules from Centers for Medicare & Medicaid Services

New, complex layers of information and documentation requirements reduce or slow payment.

"The amount of information coming out of CMS which requires providers to analyze and provide comment back to them is increasing," says John Settlemyer, assistant vice president of corporate revenue management at Charlotte, North Carolina–based Atrium Health. "Not only do we have the traditional proposed and final rules for various payment programs, but now imbedded within those rules are requests for additional information."[5] The sheer volume of back-and-forth communication is dizzying.

Despite this increased administrative cost, American Hospital Association data shows that hospitals lost nearly $77 billion in underpayments from government reimbursement programs in 2017: nearly $54 billion to Medicare and nearly $23 billion to Medicaid.[6]

"The amount of information coming out of CMS which requires providers to analyze and provide comment back to them is increasing..."

A neutral, external partner can relieve some of the administrative weight and complexity, allowing your staff to focus on patient care and save valuable time—without added HR costs.

CHALLENGE

3

Administrative work draining physician and executive resources

The demands for clinical documentation, key to reimbursement, are on the rise, and not just from new CMS regulations and escalating denials. Even the initial process of credentialing and qualifying practitioners for participation in payer networks takes a heavy toll on already overcommitted staff.

The collection and communication of additional information can be counterproductive to the achievement of your primary objective as a facility—the health and wellbeing of your patients—when it takes your practitioners away from direct patient care to spend time on administrative tasks, burning through their limited time and energy.

And as CFO, vice president or other executive, you are burdened with more than your fair share of that administration. You may be qualified to review payer contracts and lead negotiations, but just because you can manage payers doesn't mean you should. (Not alone, anyway.)

> *"The amount of information coming out of CMS which requires providers to analyze and provide comment back to them is increasing..."*

Is navigating the complexities of payer relationships and contracts the best use of your limited energy and time? Are you up-to-date on all current payer and CMS policies and procedures? Or, like many in your position, plates filled by the broad scope of your responsibilities, are you leaving managed care to manage itself?

This is where an outside partner, fully immersed in the managed care environment and experienced with multiple payers (without affiliation with any), can deliver up-to-the-minute industry advice to better inform your managed care decisions.

Such a partner is helpful in reducing your organization's administrative burden while leveraging payer negotiations and communications to recover revenue and margin that may be lost without proper, high-detail management.

With continued financial pressure from government programs, managing relationships positively with commercial health plans is often critical to maintaining profitability in operations. The need to evaluate managed care relationships has become top priority for hospitals and other healthcare providers.

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3 CRITICAL AREAS OF FOCUS:

A step-by-step blueprint for directly improving your bottom line

The key to success in improving your profit margins and revenue cycle is knowing where to strategically focus your efforts.

FOCUS
1

Payer contract review and negotiation

Get exactly what you want from your next payer contract negotiation by catching the blemishes in a contract before signing on the dotted line.

Evaluate new and existing managed care contracts for your facility and practitioners.

- Review your current managed care agreements in detail, preparing and maintaining a summary analysis of each, so you can easily compare one agreement against another.
- Analyze payer trends, with a clear understanding of potential opportunities and financial repercussions.

Negotiate terms with those payers with whom you wish to have a contract.

- Set clear goals for the negotiation, aligning contracts with organizational objectives.
- Be able to discuss market impacts of the agreement.
- Enter discussions knowing where you can be flexible and where you must hold firm.

Evaluate reimbursement and risk sharing arrangements offered by payers.

- Come to the negotiation table thoroughly equipped with data. (The payer is.)
- Using your claims data, create models to calculate the financial impact of payer offers.
- Leverage models to test potential counteroffers you may make to payers, taking the guesswork out of the process.
- Respond with the reimbursement methodologies most likely to be accepted.

Prepare practice-specific comparisons of payer fee schedules for employed practitioners.

- Benchmark payer-proposed fee schedules to your charges and Medicare, reducing the time it takes to evaluate a fee schedule.
- Establish and test physician practice fee schedules.

Communicate frequently throughout negotiations, whether for new or renewing contracts.

- Direct the intricate back-and-forth required to move negotiations forward satisfactorily.
- Be transparent with payers, sharing the complex layers of required information.
- Anticipate payer response to proposed changes.
- Meet with payers after new contract terms or rate schedules have been established.

FOCUS
2

Payer management: selection, compliance and communication

Increase revenue and boost profit through improved reimbursements by choosing the right payer for your organization, ensuring the payer's compliance and maintaining open channels of communication.

Audit ongoing payer compliance with contract payment terms.

- Carefully review past transactions for underpayments.
- Review appeals for inconsistencies in reasons for payment as well as rejection.
- Track nonresponsive appeals, where payers delay payment on certain types of accounts.

Uncover and resolve persistent reimbursement problems.

- Compile the data required to prove a pattern of late or inaccurate payments.
- Present findings to the payer and initiate corrective measures.
- Resolve late or inaccurate payment problems.

Increase day-to-day communications with payers.

- Put a dedicated team in place to open regular communication channels with payers.
- Increase coordination with key stakeholders, internally and externally.
- Meet with payers monthly or quarterly, depending on the size of contract and/or payer.

Discern the best-fit payers for your organization. (Not all payer offers are created equal.)

- Review solicitations from payers.
- Be wary of payers offering reference-based pricing options, or reimbursement based on your Medicare cost reports.

FOCUS
3

Direct contracts with self-funded employers

A study found that nearly half of Tennesseans living in rural areas who seek health care drive past the hospitals closest to their homes to look for care in more urban settings. This is true even when their local hospitals offer the same service. The authors speculated that patients may seek lower-cost care alternatives in the cities in response to patients' increasing responsibility for health care costs. How do you deal with increasing competition from lower-priced retail clinics and health networks?

Establish direct contracts with local self-funded employers and reduce their health care costs.
A direct contract, working with the employer without a payer's interference, is always more favorable for you than a third-party payer arrangement.

- Build your market share by improving the health and productivity of participants of area employers, offering a plan with an emphasis on prevention.
- Combine the concepts of accountable care, patient-centered medical homes, population management and direct contracting between employers and providers.
- Eliminate competition and drive revenue by building relationships with the community and its constituents, making your facility their health home.

In an ideal world, you and your staff would implement all the above steps: maximizing your payer relationships and contract negotiations, tracking and correcting late or under payments, and establishing direct relationships with area employers to make your health system the community's premier choice.

But what if you have neither time nor resources to manage managed care in-house?

You don't have to manage complex payer contracts and relationships alone.

It may be time to bring in an external partner, a team of experts who can take this responsibility off your shoulders—and maximize your reimbursements, at lower cost to your organization than hiring a comparable team of employees. (Hint: The step-by-step process outlined above is exactly the process we at Managed Care Partners use to help our clients recover thousands of dollars in lost revenue and build market share.)

Receive objective, expert advice and payer contract negotiation services.

At Managed Care Partners, our knowledge of payers helps you sort through which ones will benefit your organization and which ones to ignore, as well as respond with the reimbursement methodologies most likely to be accepted. We evaluate new contracts and determine whether they are a good fit for the hospital. We take every existing agreement and review and summarize it, allowing you to better assess your current contracts. We evaluate and negotiate new and existing managed care contracts for your facility and practitioners.

Managed Care Partners holds your best interests in mind, because we work only for providers, never payers. We have no affiliation with insurance companies, HMOs or commercial managed care organizations.

Access top-notch analytical tools and technology to streamline and improve decision-making.

Our team includes seasoned analysts who have navigated the payer environment for combined decades. Using your claims data, our analysts create extensive models tailored to your facility. We can then easily evaluate reimbursement and risk sharing arrangements offered by payers, as well as calculate the financial impact of payer offers and suggest counteroffers. Our Physician Fee Analyzer benchmarks a payer-proposed fee schedule to your charges and Medicare, and reduces the time it takes to evaluate a fee schedule to a matter of minutes.

Recover revenue lost to late or missed payments, and margin lost to inaccurate payments.

We have uncovered hundreds of thousands of dollars in underpayments for our clients. We take inaccuracies up with the payer, an often tedious and lengthy process, when you and your team don't have time to. We resolve persistent reimbursement problems, helping to compile the information required and taking the lead on conversations with the payer.

Build market share by directly contracting with local self-funded employers.

We assist you in cultivating relationships and establishing direct contracts with local employers, helping you to reduce employers' health care costs while eliminating your competition and cutting out the middleman third-party payer. For a deep dive into direct employer relationships, visit our YouTube channel, Managed Care Partners, and watch the video, "Build market share with employer partnerships."

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Let us be your managed care experts, so you and your team can focus on what's most important: patient care and organizational sustainability.

Managed Care Partners is your outsourced managed care department, navigating contracts and day-to-day relationships with insurance companies, Medicare, Medicaid and larger employers in your community. We stay up to date on what's going on in managed care, so you don't have to.

We're not consultants; we're administrators. We manage more than 1,000 contracts for our client providers and have worked with over 100 different payers. Our team includes attorneys, analysts and specialists in contract evaluation and negotiation, credentialing, reimbursement modeling, payment auditing and employer solutions.

We currently serve 35+ health institutions in Illinois, Indiana, Michigan, Missouri, Texas, and Wisconsin—some of whom have been clients since our inception 25 years ago, when managed care was brand-new. We can work with any facility in the U.S.

Ready to recover lost revenue and maximize payer reimbursements?

Please contact
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(630) 936-4211 or
kleitzen@mngdcare.com
for a complimentary discovery call to see how we can help.

Sources:

[1] Ellison, A. (2018, December). State-by-state breakdown of 93 rural hospital closures. *Becker's Hospital Review.* Retrieved from https://www.beckershospitalreview.com/finance/state-by-state-breakdown-of-93-rural-hospital-closures.html. Data was tracked by the North Carolina Rural Health Research Program, between January 1, 2010, and December 17, 2018.

[2] American College of Healthcare Executives. (2019, January). Survey: Healthcare Finance, Governmental Mandates, Personnel Shortages Cited by CEOs as Top Issues Confronting Hospitals in 2018. Retrieved from https://www.ache.org/about-ache/news-and-awards/news-releases/top-issues-confronting-hospitals-in-2018. The survey was confined to CEOs of community hospitals (nonfederal, short-term, non-specialty hospitals). CEOs could choose as many issues as desired. Any specific concern with fewer than 50 responses was not included. Survey sent to 1,402 community hospital CEOs who are ACHE members with 355 responses.

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[4] ACHE, Survey.

[5] Auton, T. (2019, January/February). Revenue cycle leaders are seeing increased impediments to getting paid. Retrieved from https://www.healthleadersmedia.com/finance/4-reasons-reimbursement-environment-grows-thornier.

[6] American Hospital Association. (2019, January). AHA: Medicare, Medicaid underpaid hospitals by $76.8 billion in 2017. Retrieved from https://www.aha.org/news/headline/2019-01-03-aha-medicare-medicaid-underpaid-hospitals-768-billion-2017

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