By Lauree E. Handlon

Improving Revenue Yield Through Commercial Payment Assessment

By reviewing, testing, monitoring, and resolving commercial contract terms, hospital executives will be taking proactive steps to positively influence revenue yield.

Hospitals continue to battle with determining how to maximize revenue. A key strategy in this pursuit is establishing processes to improve revenue yield—or maximizing the net payment per unit of service.[a] Many healthcare finance executives may question how this can be tactically accomplished.

With respect to commercial contracts, three strategies can help hospitals achieve revenue goals:

- Carefully reviewing and testing current payment terms against proposed new payment terms
- Checking that contract language is correctly interpreted by the payer and hospital
- Auditing the application of current contract terms to determine if payment is being applied appropriately—and taking action to correct payment errors

Testing Proposed Payment Terms

On the surface, payment term changes between a provider and payer can appear to be nominal. However, depending on the hospital's patient mix and volume of various services, radical payment differences can result from even small contract changes.

Consider the example of Cooper Lewis Memorial Hospital, a fictitious hospital, that is in the midst of payment discussions with its top two commercial payers (Payer 1 and Payer 2). The hospital is located in a metropolitan area and has approximately 25 percent market share in a four-hospital region.

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Before signing new contracts, Cooper Lewis Memorial decides to test the following payment term changes proposed by the payers (see the exhibit on page 6):

For Payer 1:

- Inpatient: Increase the inpatient Medicare-severity diagnosis-related group (MS-DRG) base rate by 33 percent.
- Outpatient: Increase and decrease some of the fixed ambulatory surgery center (ASC) and outpatient surgery group rates.

For Payer 2:

- Inpatient: Increase the MS-DRG base payment rate by 3 percent and apply a significant increase to the outlier threshold amount, resulting in fewer claims reaching the outlier payment provision.
- Outpatient: Make changes to various ASC/outpatient surgery group payments, including the multiple-procedure discount logic and emergency department (ED)-level terms for outpatient services (again, some increases and some decreases).

During the initial stages of discussions with payers, Cooper Lewis Memorial predicted that the proposed changes would be equitable. Although hospital executives recognized that the proposed new rates might result in lower payments from Payer 2 (specifically due to the stop-loss provision modification), they thought that higher payments from Payer 1 would compensate for Payer 2.

To evaluate the true financial impact, a full year of Cooper Lewis Memorial's patient claims were processed under the current and proposed terms for both payers, taking into account the hospital's current mix of services and associated volumes (see the exhibit on page 7). The analysis revealed that the hospital would indeed experience an increase in payment from Payer 1. However, the payment decrease from Payer 2 would be so significant as to produce an overall decrease.

After further investigation, Cooper Lewis Memorial leaders pinpointed three patient mix-related factors behind the major revenue decrease from Payer 2's proposed contract changes:

- The stop-loss threshold change increased the hospital's charge threshold by more than 43 percent.
- More than 50 percent of the hospital's ED visits were assigned to Level 3, which happens to be the level experiencing the greatest decrease in payment under Payer 2's proposed new terms.
- More than 75 percent of the hospital's outpatient surgical services were associated with those outpatient surgical groups receiving a proposed decrease in payment.

Overall, the modest suggested changes to a few payment terms from both of Cooper Lewis Memorial's payers produced large swings in revenue yield, which would affect the hospital's ability to remain operational and benefit the surrounding

a. In the article, "Traits of Higher-Paid Hospitals," in the Summer 2013 issue of this newsletter, we used the net patient revenue per equivalent discharge™ metric to illustrate how pricing leverage represents the strongest factor in distinguishing higher-paid facilities.

community. Understanding how these changes created the revenue differences is key to negotiating contract terms and/or determining contract areas that need to be improved in future payer negotiations.

Ensuring Clear Contract Terms

Hospital finance leaders should also seek to enter agreements in which specific contract language and payment methodologies are settled on and sufficiently stipulated in the written terms. How contract terms are interpreted can be very different from payer to hospital. Inappropriate reimbursement often occurs from confusion or vagueness in contract language. Sometimes such ambiguity can favor the provider and sometimes the payer.

The confusion generally stems from several specific areas, including the following:

- Missing or unclear contract term definitions (e.g., omission of MS-DRGs, ICD-9 codes, revenue codes, a combination of codes, etc.)
  - For example, for cardiac surgery carve outs, the term "cardiac surgery" needs to be clearly defined in MS-DRG or ICD-9 codes.

Payer Comparison: Current Rates Versus Proposed Rates

Payer	Payer 1: Current	Payer 1: Proposed	Payer 2: Current	Payer 2: Proposed
Inpatient Services				
General				
MS-DRG base rate	$7,235	$9,651	$7,465	$8,688
Stop loss				
Stop-loss 1: Threshold	$116,600	$116,600	$69,812	$100,389
Stop-loss 1: Total charges paid at %:	38.00%	38.00%	54.50%	47.50%
Outpatient Services				
Multiple procedure discount	1st = 100%; 2nd and beyond = 50%	1st = 100% 2nd and beyond = 50%	1st = 100%; 2nd only = 50%	1st = 100%;
Outpatient surgery				
Group 1 case rate	$1,096	$1,149	$952	$932
Group 2 case rate	$1,362	$1,686	$1,317	$1,289
Group 3 case rate	$2,069	$2,484	$1,829	$1,790
Group 4 case rate	$2,195	$2,195	$2,340	$2,290
Group 5 case rate	$4,065	$4,258	$2,927	$3,125
Group 6 case rate	$2,507	$2,507	$4,390	$4,450
Group 7 case rate	$4,877	$4,585	$4,683	$4,585
Group 8 case rate	$4,690	$4,690	$4,098	$4,098
Group 9 case rate	$6,952	$6,237	$4,390	$4,390
Ungroupable (% BC)	64.39%	64.39%		
Ungroupable case rate			$1,464.05	$1,464.05
ED				
Level 1-99281-case rate	$190	$190	$322	$322
Level 2-99282-case rate	$477	$477	$322	$535
Level 3-99283-case rate	$689	$689	$1,096	$874
Level 4-99284-case rate	$1,219	$1,219	$1,609	$1,279
Level 5-99285-case rate	$1,961	$1,961	$1,609	$1,650

Source: Cleverley & Associates; data is for a fictional hospital/payers based on actual scenarios.

In this fictional example, Cooper Lewis Memorial Hospital compares payment term changes proposed by two payers to the current terms.

- A template contract applied by the payer, which includes language not applicable to the current hospital terms
- Contract language with missing specifications about payment methodology (e.g., a vaguely defined hierarchy of payment, services paid in addition to, lesser of logic, omission of inclusions/exclusions to certain rates, etc.)

Before signing payer contracts, healthcare finance leaders should invest needed time in identifying missing, vague, or unclear terms—and reworking the contracts as necessary. In addition, finance leaders need to establish that all language is relevant to the current contracts and that the payment hierarchy methodology is well-defined.

Once payment terms have been discussed and a draft contract has been created, hospital executives should consider involving the health information management (HIM) department. HIM can provide the expertise related to MS-DRGs, ICD-9-CM/PCS codes, healthcare common procedure coding, and revenue codes. They can help confirm that the language related to specific code sets is clear and complete.

Monitoring Payment Term Application

Once a hospital agrees to payment term changes, it needs to address another significant issue: Are contract terms being monitored to ensure that payment is being calculated correctly? The incorrect application of commercial contract terms is a primary cause for incorrect payment.

To confirm that contract terms are being applied appropriately, hospital finance executives should consider periodic audits. Commonly, quarterly internal reviews are performed with a focus on specific high-volume service areas. However, the most problematic contract terms for payers to adhere to involve carve-out services. Many times, carve-out services involve implants and prosthetics, high-cost drugs, or any service paid in addition to other services. Another problematic area for payers is instituting term changes on the correct effective date.

How contract terms are interpreted can be very different from payer to hospital. Inappropriate reimbursement often occurs from confusion or vagueness in contract language.

By comparing expected to actual payments for approximately 10 percent of claims in each payment category by month, errors will surface without consuming a lot of internal resources. Then hospital executives will be armed

Results of Processing Current and Proposed Terms for Two Major Payers

		Current Terms			Proposed Terms				
Contract	**Patient Type**	**Original Charges**	**Final Payment**	**Payment %**	**Original Charges**	**Final Payment**	**Payment %**	**Difference $**	**Difference %**
Payer 1	Inpatient	$5,603,375	$1,323,678	23.6%	$5,603,375	$1,654,179	29.5%	$330,501	25.00%
Payer 1	Outpatient	$10,261,438	$2,983,094	29.1%	$10,261,438	$3,105,400	30.3%	$122,306	4.10%
Payer 1 subtotal		**$15,864,813**	**$4,306,772**	**27.1%**	**$15,864,813**	**$4,759,579**	**30.0%**	**$452,807**	**10.5%**
Payer 2	Inpatient	$3,163,306	$1,406,810	44.5%	$3,163,306	$990,099	31.3%	($416,711)	−29.60%
Payer 2	Outpatient	$8,795,826	$2,580,772	29.3%	$8,795,826	$2,012,535	22.9%	($568,237)	−22.00%
Payer 2 subtotal		**$11,959,132**	**$3,987,582**	**33.3%**	**$11,959,132**	**$3,002,634**	**25.1%**	**($984,948)**	**−24.7%**
All other payers	Inpatient	$19,745,582	$7,475,519	37.9%	$19,745,582	$7,475,519	37.9%	$0	0.00%
All other payers	Outpatient	$47,764,797	$14,594,610	30.6%	$47,764,797	$14,594,610	30.6%	$0	0.00%
All other subtotal		**$67,510,379**	**$22,070,129**	**32.7%**	**$67,510,379**	**$22,070,129**	**32.7%**	**$0**	**0.0%**
		$95,334,324	**$30,364,483**	**31.9%**	**$95,334,324**	**$29,832,342**	**31.3%**	($532,141)	−1.75%

Source: Cleverley & Associates; data is for a fictional hospital/payers based on actual scenarios.

This analysis revealed that the hospital would experience an increase in payment for Payer 1 under proposed terms. However, the payment decrease from Payer 2 would be so significant as to produce an overall revenue decrease.

Review of Expected Payments to Actual Payments

Payer	# Claims Identified	Issue Identified	Patient Type	Total Charges	Expected Payment	Actual Payment	Difference
Payer 1	12	Payment term change effective 7/1. It appears that payer is still using rates effective prior to 7/1.	Inpatient	$909,084	$247,267	$231,813	($15,454)
Payer 1	7	It appears that claims were paid at initial contracted rates, when stop-loss provision should be applied.	Inpatient	$1,585,699	$392,850	$281,136	($111,714)
Payer 1	98	ED claims: It appears that they were paid at the all-other-outpatient rate	Outpatient	$117,600	$103,488	$67,032	($36,456)
Payer 1	125	Payment term change effective 7/1. It appears that payer is still using rates effective prior to 7/1.	Outpatient	$1,487,500	$536,250	$446,875	($89,375)
				$4,099,883	$1,279,855	$1,026,856	($252,999)

Source: Cleverley & Associates; data is for a fictional hospital/payer based on actual scenarios.

During a payment audit, a fictional hospital found 242 occasions in which actual payments from one payer were below expected payments.

with the information they need to determine if further investigation and action is warranted.

In addition to internal audits, hospital executives should explore instituting a yearly external audit. External audits would involve *all* claims in a particular time period to be reviewed for payment accuracy. Although internal audits are ideal, often the resources to perform these audits are not available and external audits may be the only option. Ideally, hospital executives want to determine issues immediately so payment problems can be resolved quickly to ensure proper current and future payment.

To confirm that contract terms are being applied appropriately, hospital finance executives should consider periodic audits.

Take for example our fictional hospital. It has been a few years since Cooper Lewis Memorial Hospital had analyzed payments from a major payer. For this payer, inpatient services account for approximately 26 percent of the revenue and outpatient services represent 74 percent.

The exhibit above provides the results of reviewing expected payments based on contractual terms against actual payments. On 242 occasions, actual payments from this payer were below expected payments. The primary areas causing discrepancy included the following:

- Old contract terms were applied to claim dates of service under new terms.
- Stop-loss terms appeared to be disregarded.
- ED claims were paid using the all-other-outpatient rate instead of the contracted ED rate.

The differences identified amounted to more than $250,000 in lost reimbursement in just four service areas.

Review, Test, Monitor, and Resolve

When governed appropriately, commercial contract terms can have a major positive influence on a hospital's revenue yield. It is essential to review current payer terms and test proposed contract modifications on both inpatient and outpatient services before entering any agreement. The results provide answers to revenue variation and, subsequently, can be used to determine specific service areas to strategically adjust.

Once terms have been finalized, continuous auditing of the agreed terms is necessary to ensure proper payment. If discrepancies occur, the hospital must have processes established to collaborate with the payer on correct payment determination.

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