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Hospital Contracting Best Practices

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Overview

This article presents information from a recently completed client-sponsored survey of hospital contracting best practices. Individual health plans were evaluated using a structured survey document. The primary objective of the survey was to identify best practices that the client sponsor could implement to improve its already better-than-average hospital contracting practices. Surveyed health plans included plans covering members throughout the United States.

The survey included several sections covering the following contracting topics and issues:

- Organization and people
- Reimbursement methodologies and administration
- Negotiating tactics for working with hospitals
- Negotiation tactics for data and analysis.

All aspects of the hospital contracting process were included in the survey, resulting in a complete summary of observed best practices.

Definition of Best Practice

For purposes of this survey, we defined best practice as "best observed practice." Observations include the responses of the surveyed health plans, in addition to the author's experience with hospital contracting as a consultant and working for contracting organizations. A best practice might involve a solution to a long-standing contracting challenge that was quite creative and one that other plans wished they were doing or were trying to develop. Or, it could be a differentiating practice (e.g., commitment to collaborative contracting). Another option is that it may be a practice that other plans specifically commented on and others were working to improve it and one or more plans were already doing it.

Organization and People

For the topic of organization and people, the following three key areas are noteworthy: actuarial reporting structure, assignment of duties and incentives. With regard to the actuarial reporting structure, it's clear that the organizational best practice has actuaries directly involved with the hospital contracting process. Two distinct variations emerged, one referred to as an "integrated" model and the other as a "parallel" model. The integrated model had actuaries embedded in the provider contracting department reporting up through its leadership. The parallel model similarly embedded actuaries, but maintained reporting through the chief actuary. The differentiation was the use of dedicated actuaries to support the contracting and medical economics activities.

The best practice for the assignment of duties was identified as a plan where contracting personnel were responsible for contracting all providers within a specific region, as compared to responsibility for contracting just hospitals across broader geographic areas. The primary advantage of this was a greater awareness of the scope and characteristics of the network. For incentives, the best practice included specific financial incentives for provider contracting staff meeting specific objectives.

Reimbursement Methodologies and Administration

Reimbursement methodologies and administration includes four attributes consisting of the use of a model contract, the length or term of the contacts,

the reimbursement methodology and the fully adjudicated hospital payment rate.

First, the best practice for the use of a model contract utilized a standard "model" contract with extremely limited exceptions (i.e., less than 5 percent of contracts involve exceptions). This approach led to streamlined, more efficient and less costly contract administration.

Second, the term of contacts' best practice was identified as longer term contracts (i.e., at least three years, preferring as long as five years) with automatic adjustors from year to year.

Third, the best practice for methodologies was identified as case rate reimbursement utilizing DRGs. The results were equally split between CMS DRGs and AP-DRGs, although internal severity adjusted analysis was based upon either APR-DRGs or R-DRGs.

And fourth, fully adjudicated hospital payment's best practice was identified as more than 95 percent of hospital claims being fully adjudicated by an automatic system.

Negotiating Tactics with Hospitals

The third contracting topic relates to negotiating tactics when working with hospitals. This category has a number of areas for comment, which are outlined as follows:

- **Collaborative contracting.** The best practice was identified as a collaborative contracting process where health plan and providers worked together in a non-confrontational basis. As a result, relationships were more satisfying along with better results and longer term contracts.

- **Benefit design.** The best practice was identified as flexible and able to handle new products (i.e., tiered networks, consumer driven health plans, etc.)

- **Hospital systems.** The concentration of bargaining power by hospital systems and provider groups causes challenges for all health plans. Thus, the best practice was the "divide and conquer" strategy wherein each individual hospital is considered on its own.

- **Process during contract change.** Several surveyed plans have executed major contract changes in recent years. Multiple approaches were used to introduce the changes; however, the best practice and most effectively reported process are characterized as a "just do it" method. Although any change causes concern among providers, it appears that getting it over with as quickly as possible gets the best results.

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- **Negotiation timeline.** The best practice has been defined as the plan with the consistently shortest process. The shortest timeline was a consistent period at or below 60 days. This also occurred with the plans utilizing the collaborative process. The plans with the highest self-reported antagonism with providers also reported the most extended timeline.

- **Contracting incentives.** The best practice involved the use of contracting incentives that rewarded providers for early adoption of changes or signing bonuses for shorter negotiation time periods. The negotiation timeline was the shortest for those offering signing bonuses.

Negotiation Tactics for Data Collection and Analysis

The final topic within negotiation tactics has three elements for best practices of data collection and analysis. These are renewal contracting analysis, sharing of data and monitoring of results.

For the first, the best practice included the development of a standardized renewal package for each hospital contract. This process is fairly similar to standardized underwriting processes, but applied to the hospital contracting process. The renewal package includes a set of standard reports and analysis to facilitate a consistently structured negotiation process. Plans utilizing this approach also exhibited results more consistent with their objectives.

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Next, the best practice for sharing of data was open distribution of information with hospitals ensuring the consistency of data between the plan and the provider. The most effective processes were observed with plans with the most collaborative contracting styles.

In terms of monitoring of results, the best practice was an integrated database tool that enabled stakeholders to obtain real-time information on both expectations of contracting (i.e., assumed trend rates) and actual results (i.e., actual trend rates and costs). The most innovative approach was labeled a "checkbook," where finance and the actuarial department initially identified the targets, and actual results were updated in real-time presenting a "gap" analysis. This active two-way communication process provided quicker updates to the pricing actuaries if rates required revisions and, at the same time, provided meaningful information for negotiators to strive for improved results (as necessary).

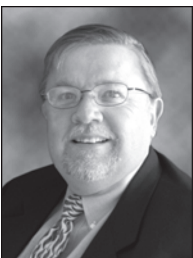
Additional Observations

Although there wasn't a plan that exhibited all of the above-mentioned best practices, many of these practices are, or could be, interrelated. The key observation from the survey is the benefits or advantage of collaborative contracting. Many health plans believe a "tough guy" approach will achieve better results. However, our observations and experience in the market suggests the counter-intuitive collaborative approach achieves the best results.

Consider a situation where the provider and the health plan are mutually pursuing a "win-win" contract as in a contract that achieves appropriate revenue for the hospital and a contract that is in line with competitive premium objectives for the health plan. This will likely produce a long-term contract, bringing about reduced contracting expenses. This will also likely motivate additional collaborations where the provider and health plan could work together to achieve further benefits for both organizations such as integrated care management, improved disease management programs and more favorable relationships with physicians.

As far as analysis is concerned, the broader introduction of actuarial science (preferably integrated with clinical insights) improves the financial viability of contracting efforts. More plans are recruiting additional actuarial resources to provide leadership in contract analysis, medical economics, medical informatics and other areas. Introducing skilled actuaries to other aspects of analysis desperately needing their expertise can vitalize the actuarial profession, often bored with traditional pricing and reserving analyses.

As the cost of care continues to rise, the provider contracting effort becomes even more important to a plan's success. As the plan recruits the best underwriters, care managers, pricing actuaries and sales staff, the plan must also consider the value of introducing highly skilled professionals to add to the plan's sophistication in reviewing, analyzing and negotiating its provider contracts.



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