Leadership in the New Healthcare

Payor Portfolio Analysis

Shaping Top-Line Revenue

Trends such as big data, transparency or value-based care have the potential to consume a healthcare providers' strategic initiative agenda for many years. But today, hospitals of all sizes, status, and affiliations are learning the hard way that there is no luxury in being able to address these independently.

The growth of consumerism within healthcare, spurred by the Affordable Care Act and the broad-based trend of disintermediation across industries, has brought forth an outpouring of raw, unfiltered, non-contextualized information. Most of the healthcare information now publicly available was historically guarded, not to deceive the consumer, but because those who work intimately within the field know that the current system is complex and challenging to understand with all the variables that go into the delivery of healthcare.

Today, providers are beginning to adjust so that their numbers can talk — with intelligence and accuracy — for a variety of audiences. Some of this transparency is being forced through the expanded public release of charge and payment information while others are led by hospitals themselves in an effort to meet consumer desires and expectations. Even commercial insurers are partnering with each other to consolidate payment databases and make them available for public consumption. As the sources of information vary and each presents a slightly different vantage point, it's no surprise that many providers remain unprepared to meet the growing needs of the new healthcare world where big data and transparency drive investments in technology and people to deliver high quality care in a low cost environment.

Executive Worksheet

Managed Care Contract Portfolio Analysis

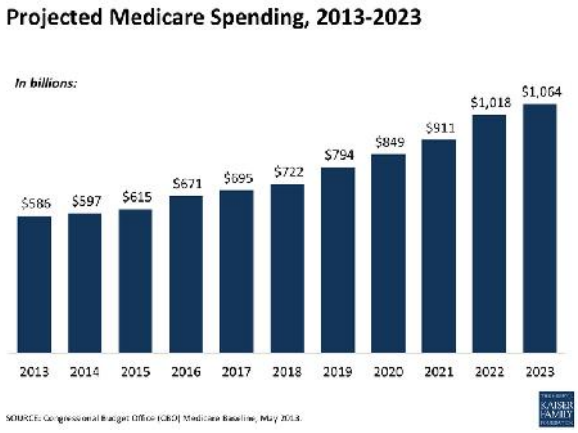
- Net Revenue Leakage
  - Actual to Expected Payment Analysis
- Departmental Performance
  - Year over Year Rate and Volume Impact Separation
- Profitability Analysis through Cost Coverage Ratios
- Average Length of Stay Trends, overlaid with year over year Volume and Payment per Case changes
- Utilization Shifts
  - Evaluation of where volumes are growing, lagging, shrinking
- Percentage of Medicare Metrics
- Compound Annual Growth Rate Trends
- Payor Parity and Relative Payment Positions
- Percentage of cases and incremental dollars from stop-loss terms
- Quantified impact of lesser of language

Where do you stand?

How do providers know if they are high quality and low cost? We can look at core measure results, patient satisfaction scores, clinical efficiencies, public charge data, reference the Hospital Strength INDEX or a variety of other data points to try and answer these questions objectively. Unfortunately, there is no standard by which the US Healthcare System ranks its providers. Consumers consequently struggle in the process of comparing while payors and providers publicly spar over which criteria to tout as important in the evaluation of effective care.

Defining Commercial Contract Needs

Assessing how providers measure up with regard to quality of care and cost of service is only part of the story. It's the part that consumers are most concerned about, but what do providers need in order to adapt and remain financially viable in that environment? They need metrics that track trends within their own utilization, reimbursement rates that are aligned with resource consumption and value provided, a collaborative approach with payors, and to minimize the risk associated with environmental factors.



Medicare and Medicaid spending currently account for 22% of the entire federal budget, covering 115 million beneficiaries to the tune of nearly one trillion dollars. One in three Medicare patients are now enrolled through Medicare Advantage plans, and state expansions of Medicaid continue to build growing consumer demand in a high risk population. When analyzing these trends in governmental utilization, providers express concern over patient bad debt growing, routine reductions in payor reimbursement, and continued margin pressure on their commercial payor populations. Studies by the Medicare Payment Advisory Commission have continually found that hospitals operate at a negative margin when it comes to caring for these patients, often falling within the range of 90-95% of cost.

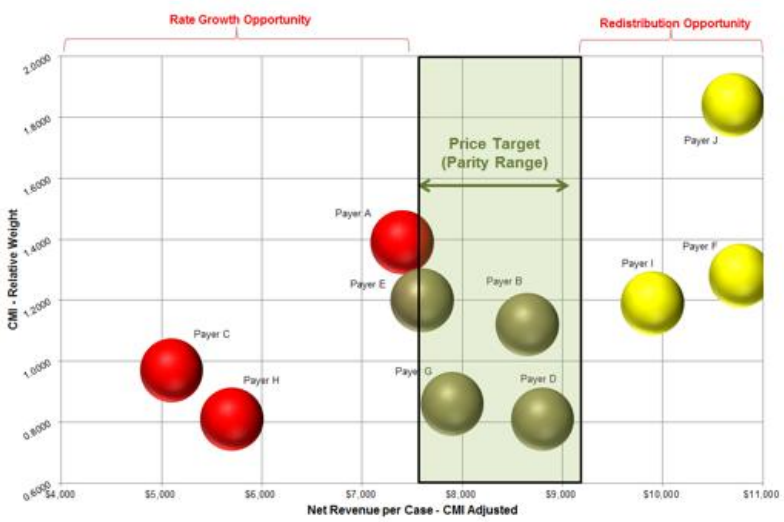
So as enrollment numbers for Medicare and Medicaid increase, hospitals must squeeze more out of their commercial payor contracts to cover the cost of uncompensated care within this population. And this is no easy task as all providers are essentially competing for the same set of consumers within the same set of payors. The framework is set up so that consumers have the ability to choose their insurer and their care provider in most situations, but providers do not choose their patients. The cost of treatment varies in accordance with patient specific variables, not payor differences, and it is this fact that highlights the overwhelming case for building a narrowly defined range of parity across reimbursement contracts.

The Relevance of Parity

The alignment of incentive structures between payor and providers to more value-based reimbursement is simply not a change that occurs overnight. It requires extensive planning, the establishment of baseline statistics, and active monitoring over a period of a year or more before any financial improvements are realized by providers. While these types of contracts are inherently appealing for providers and payors alike, the projection of reimbursement dollars coming from value-based contracts is anticipated to grow to a size of 30-40% of total payments in the next three years. This growth illustrates that for the majority of providers, a traditional fee-for-service model will still be relevant for 60-70% of their patient revenue.

When providers are competing based upon volume type models, high levels of volatility across commercial contracts brings an inherent risk as environmental factors outside their control can have a resounding impact on the bottom line. If one contract reimburses a provider at a rate that is 50% higher than another, that's either a very big risk or a large opportunity for improvement.

- What would be the financial impact if the lower reimbursing payor bought the higher reimbursing one?
- What if the largest employer group decided to change insurers from the lowest reimbursing payor to one that was more consistent with the portfolio average?



Measuring contact performance helps managed care team identify opportunities for revenue growth and establish targets.

In the largely fee-for-service world of today, most healthcare providers have a commercial payor portfolio that reflects a relatively narrow range of parity at a macro level with a broader distribution range of payment when analyzing lower levels of detail. Within the more detailed views by specific patient types, financial classes, and service lines is where surprises are most often found. The measurement of volatility and relative payor position, both within payment and volume statistics, is an ingrained characteristic of high performing providers.

Do the Medicare Advantage contracts yield better payment than Traditional Medicare? Are we financially better off to have orthopedic volume growing for Blue Cross or Aetna? How does the Genentech reclassification of common chemotherapy drugs to "specialty" status impact our reimbursement and does the answer vary by payor? What is the spread of payment ranges between emergency room levels one and level three visits?

Being able to answer these types of questions sets the pathway for where to move commercial payor negotiations. There are always going to be repairs to make and concessions to give within commercial contracts, but the key is to be consciously aware of what those elements are and their quantified impact as adjustments are made.

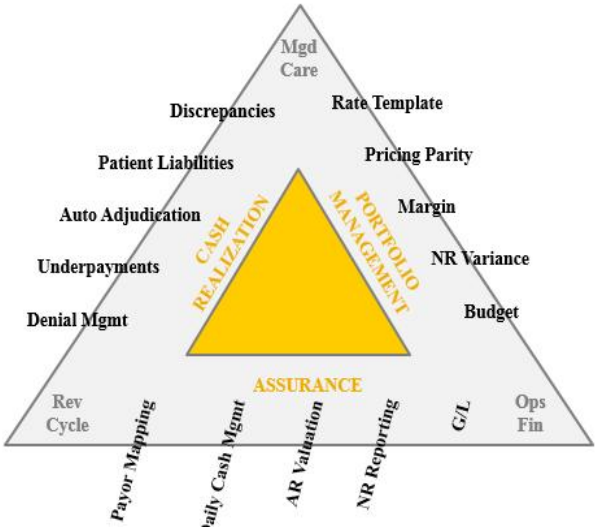
Collaborative Perspective

Consistent introspective analysis can unlock a wealth of opportunities that exist today within any provider's managed care portfolio by employing what we commonly refer to as a 3D – Define, Defend, Deliver – Strategy. This centers on engaging finance, managed care, and clinical departments to collaboratively develop and implement managed care portfolio strategies, pricing targets, and payor negotiations. Pricing logic and rates must be defined to be sensitive to resource consumption, procurement costs, changes in length of stay, contribution margin, and not payor driven

Advisor Advice

The emergence of pricing transparency means that contract rates and charges must defensible with payors, employers and consumers.

(Medicare, Medicaid, HMO, PPO, etc.). In the wake of growing transparency, contract rates and charges must also be defensible with payors, patient population, and employers. Payor negotiations and their associated preparation, navigation, and execution must deliver financial results under sustainable, repeatable processes. A successful negotiation requires ample planning and a clear understanding of organizational objectives in conjunction with improvement metrics.



Build Your Baseline (and update it!)

Providers have a tremendous amount of raw data available today, but the problem that many encounter is the translation of these elements into meaningful, actionable insights. When working with Big Data, the key is demanding standardization in how the information is organized while allowing flexibility to explore unique combinations. In our work with a great variety of providers from community to specialty, for-profit to not-for profit, independent to system affiliated, the impact of establishing and monitoring against a baseline of core managed care metrics never ceases to impress our clients. It drives accountability, empowers departmental teams, highlights specific payor and service line opportunities, quantifies risks, and lays the foundation for establishing prospective rate targets using a data driven-approach.

Although contracted rates and language terms may not change every year, utilization and actual contract yield differences can account for significant changes within a short period of time. As patients move from commercial insurance to Medicare, from self-insured to exchange plans, from urgent to elective care, the impact to the bottom line is felt throughout the organization. Having a consistent, systematic update schedule for payor metric reports enables an organization to objectively measure change and make adjustments when necessary.

This holistic approach of mining payment data by all payors, products, financial classes, and service lines is known to our clients as the Managed Care Portfolio Analysis. We've been able to leverage our experience with these large datasets to create top line revenue growth by building complex data stratification algorithms that quantify risk and opportunity across a spectrum of 130 inpatient and 80 outpatient service lines so contract negotiators know where to push for increases and where to strategically plan for redistribution. Once the data classification schemes are built, we turn to a collaborative approach to define the right metrics for what resonates with each facility.

Meet Our Expert

Randy Bury works closely with hospitals and systems to help them better understand reimbursement performance relative to other payors and peer facilities, grow and stabilize service line profitability, and develop actionable plans for strategic improvement through contract negotiation.