

PAYMENT

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healthcare financial management association www.hfma.org

managed care contracting and payment reform avoiding a showdown

Since healthcare reform legislation was enacted in March, many payers and providers may have noticed a heightened level of tension at the negotiation table. After all, many providers are approaching their upcoming commercial contracting cycle as their last chance to get a sizeable rate increase before cuts occur. However, payers face several immediate coverage mandates that require them to immediately minimize their unit reimbursement increases to providers. The result? A sizeable increase in the number of recent contract battles between large payers and providers.

So what are providers to do? How can such battles be prevented as reform plays out across our industry? The key to avoiding these public battles and distractions boils down to three proactive steps:

- > Recognize the dead ends with your traditional payer relationship model
- > Formulate your own transition plan to a value-based contracting model
- > Avoid operational potholes along the way

Action 1: Recognize Your Dead-End Payer Relationships

Let's face it. Years of cost shifting and negotiations have not created payer/provider relationships that foster shared vision, trust, and accountability. Rather, most payer-provider relationships have become a game of "cat and mouse," as illustrated by the following tactics to optimize revenue and take it back. For example, consider some of the revenue optimization tactics payers accuse providers of:

- > Use of sophisticated revenue maximization software that bills an inpatient case rate versus an observation day (or two) with unbundled ancillary tests
- > Use of a different tax identification number to maximize reimbursement under site of service contract terms
- > Increasing gross charge amounts to hit inpatient outlier payment clauses, with limited attention to the defensibility of those gross charges or the medical necessity of an extra day of care
- > Extra tests, procedures
- > Creative assignment of billing units in lab, pharmacy, minute charges, etc. to maximize revenue

On the flip side, consider some of the tactics providers accuse payers of:

- > Unilateral payment policy changes, including no or significantly reduced payment for multiple procedures and unilateral bundling logic changes that unexpectedly reduce unit reimbursement

AT A GLANCE

Health reform promises to fundamentally change what and how CMS and commercial payers reimburse providers.

Providers need to transition from their traditionally adversarial, transactions-based payer relationships to ones that optimize purchaser and patient value for the dollar. To avoid negotiation table showdowns and to prepare for reform, commercial payers and providers should take three actions:

- > Recognize the dead ends with their historical relationships
- > Formulate their road map to value-based contracting
- > Avoid operational potholes along the way

| PAYER/PROVIDER: A PRISONER'S DILEMMA | | |
|--------------------------------------|---|---|
| | Provider Stands Firm | Provider Collaborates |
| Payer Stands Firm | Scenario 1: Stalemate. Cat-and-mouse games continue to reduce customer value rather than create it; odds of rate regulation increase. | Provider develops programs to reduce excessive readmissions, ED visits, etc.—and loses margins that fund other services in the process. |
| Payer Collaborates | Payer loses because its investments (e.g., IT, new programs, etc.) may not go to initiatives that ultimately improve quality or save its customers money. | Scenario 4: Each party coordinates delivery and payment over a multi-year transition period (e.g., 2011-15) using reform and CMS “Value-Based Purchasing” policies as guideposts. |

> Unilateral medical necessity policy changes for new types of procedures and tests, such as genetic testing, for which limited data exist

Extrapolate these costly “cat-and-mouse” games out a few years, and the lose-lose path payers and providers are on comes into focus. In scenario 1, payers and providers continue to play the traditional game, which costs the system valuable resources in the form of audits, legal and consulting fees, contract revisions, and software to “catch each other in the act.” At an extreme, this scenario is exemplified by the hypothetical community where most of the citizens work for large, self-insured health systems that spend hundreds of millions of administrative dollars *more* than needed to deliver high-quality, efficient, and accessible care. It is just a matter of time until the community catches on to the costly administrative and delivery activities, and the state or federal government legislates premium rate caps or even cost plus reimbursement rates because the market could not agree to a more enlightened value-based approach.

To make matters worse, two of the three remaining scenarios are unlikely to emerge in this “prisoner’s dilemma,” because each party will be worse off if it decides to cooperate, but the other party does not. For example, assume the community-based provider extends an olive branch to implement a “medical home” initiative with their top payers to improve access, quality, and efficiency. Then to its dismay, the provider loses a sizeable amount of margin-generating inpatient admissions and emergency department utilization because of improvements in primary care access and coordination.

On the flip side, imagine the payer agrees to invest a sizeable amount in support of a major electronic medical record project—only for the provider to spend those dollars on an unrelated project, or in a manner that does not generate a clear ROI. Place these fears within the context of the current payer-provider relationship, and no wonder both sides are reluctant to explore how they will cooperate to navigate the waters of payment reform.

Action 2: Design Your Road Map to a Value-Based Contracting Model

Reform establishes several milestones over the next five years. The emergence of hospital-physician bundled reimbursement, disproportionate share payment cuts, primary care incentives, and penalties for readmissions are but a few of the game changers over the next few years. These game changers will require payers and providers to jointly plot their payment and delivery investments required to achieve the “Triple Aim” of lower per capita costs, improved health, and improved patient care experience (Berwick, D., Nolan, T. W., and Whittington, J., “The Triple Aim: Care, Health, and Cost,” *Health Affairs*, May/June 2008, pp. 759-769).

Payers and providers that recognize these game changers will be more likely to avert showdowns at the bargaining table, let alone further state and federal interventions. They will be more willing to share data to set utilization, mix, quality, and efficiency targets, as well as plans to reduce unnecessary costs/ complications. They will be in a better position to establish a clear vision for how their organizations

| FROM "CAT AND MOUSE" TO COMMON GROUND | | |
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| Providers' Accusations/ Misconceptions of Payers | Common Ground: Transitioning to a New Payment System | Payers' Accusations/ Misconceptions of Providers |
| Payment delays and inaccuracies Unilateral payment policy changes New medical necessity policies Unilateral coverage changes | Stop the "cat-and-mouse" games Set your sights on the "Triple Aim" of improved health, improved care experience, and lower per capita costs Share data to help set targets around quality improvements, avoidable utilization, and cost Jointly invest in specific, positive ROI investments to achieve the Triple Aim | Upcoding Billing optimization, including site of service, outlier and units of service loopholes, etc. High ancillary utilization and/or readmission rates that offset payment cuts |

need to cooperatively focus on understanding patient behavior and align patient, provider, and payer incentives to seek and deliver high-quality, efficient care.

Action 3: Avoid Operational Potholes on the Journey

Several challenges await payers and providers along the road to reform. We observe that some early moves help position organizations for success.

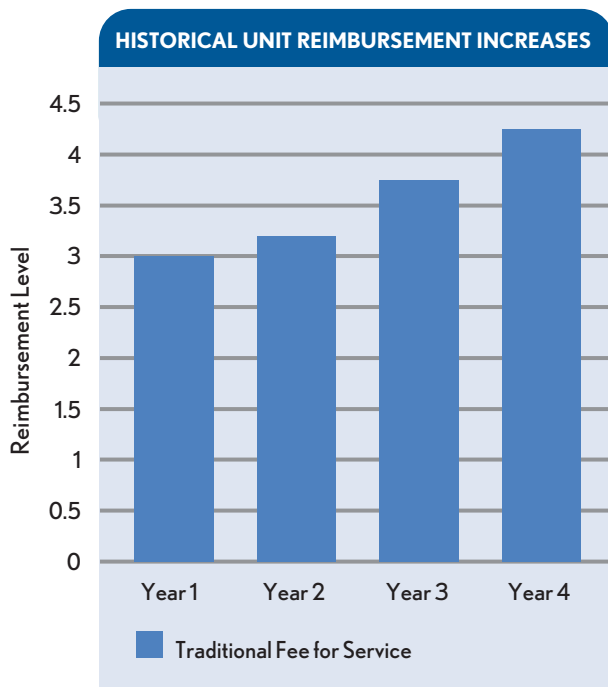
First, consider establishing three subteams to design and develop the models of care, payment changes, and incentives necessary to fundamentally improve access, affordability, and quality.

The models of care subteam should focus on quantifying potentially avoidable costs/complications/variations from claims adjudication to care delivery processes. They should also be charged with finding/implementing the fixes (e.g., supply standardization, throughput improvements, and care transition models) that will result in measurable improvements.

Similarly, the incentives subteam needs to identify areas where incentives, awareness, and additional skills are necessary to execute on the delivery process changes.

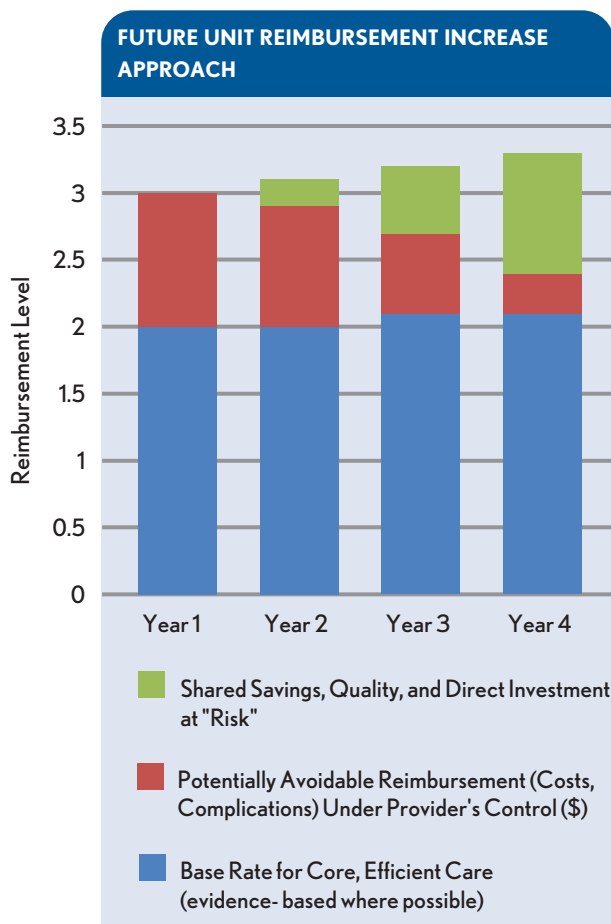
Finally, the payment team should focus on working with payers to establish base reimbursement rates

| FROM COMMON GROUND TO COMPETITIVE ADVANTAGE | | |
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| Providers' Emerging Basis of Competitive Advantage | Payers' Emerging Basis of Competitive Advantage | Payer-Provider Differentiators Together |
| Control the funds flow into the system Make money on Medicare Evidence-based care models (acute, chronic) Match supply (scale) and demand to optimize productivity of current capacity (rather than build new capacity) | Very lean cost structure Lowest unit payment Reasonable member utilization rates Ability to steer patients to low-cost sites of care using tiered networks, domestic tourism, and benefit design | Greatly simplified set of fee schedules with fair and reasonable base rate plus value-based multiplier that incentivizes providers to demonstrably improve quality, costs, and access Ability/systems to quantify and predict patient/member behavior and compliance with standard protocols—as well as avoidable costs, complications, etc. |



that cover the costs of core, efficient care—plus a set of savings that are shared if the payer/provider can eliminate potentially avoidable costs/complications/variance from the system.

A particularly noteworthy pothole exists for physicians who earn 200+ percent of the Medical Group Management Association’s reported average salary, have significant ancillary revenues, and benefit from using another organization’s tax ID for billing purposes. For these physicians, change will be most difficult because future reimbursement levels may not cover salary without additional subsidies. These groups will need to understand the payer, purchaser, and community’s perspectives, and have an opportunity to maintain current revenue/income, through a combination of shared savings and performance bonuses funded by the payers. But in most circumstances, these groups may simply need to acknowledge that the future may not be as lucrative as the past.



A third potential pothole relates to inadequately investing in the IT and reporting systems required to set performance targets and adjudicate a base reimbursement rate times a value-based multiplier. For payers with dozens of complex fee schedules (e.g., conversion factors, site of service, and professional/technical components), this transition will be particularly costly. At the least, investments in bolt-on software to identify avoidable costs and add a value-based multiplier to a base rate are critical to set the course toward value-based reimbursement.

Summary: Avoiding a Showdown

Healthcare reform is changing how payers pay for care. Unless payers and providers team up to manage the transition, the number of public stand-offs between these parties will increase substantially. Hospital finance executives play an important role in proactively exploring how to avoid such showdowns and moving the payer relationship beyond the next transaction. Provider finance leaders need to recognize the dead-end “cat-and-mouse” games of the past, design their value-based contracting road map, and navigate, potholes along the way. ●

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