# Cover Story - December 2005

## No Small Change
## Payment Trends Call For Big Preparations For 2006

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**At a Glance**

Payment trends that hospitals will need to respond to in 2006 are related to five areas of concern:

- The need to audit commercial insurers' payment for accuracy
- The need for contract modeling and data-driven organization
- The shift of volume risk from payers to hospitals
- The shift of cost risk from payers to hospitals
- The rise of consumer-directed health plans and related pay-for-performance and tiered pricing initiatives

Payment trends in 2005 posed severe challenges for hospitals due to changing payment methods and increased denials and underpayments. What trends should you look to in 2006 to protect your financial performance?

Quality in a product or service is not what the supplier puts in. It is what the customer gets out and is willing to pay for. A product is not quality because it is hard to make and costs a lot of money, as manufacturers typically believe. This is incompetence. Customers pay only for what is of use to them and gives them value. Nothing else constitutes quality.
—Peter Drucker

Hospitals will need to spend a lot more time in the coming year thinking about what their patients want. The growth of consumer-directed health care is an important payment trend that will command the attention of hospital financial leaders. Other trends that will directly affect consumers' access to and perception of health care are the emergence of pay-for-performance initiatives and tiered pricing.

But the important trends do not involve only consumers. Other important trends are affecting the relationship between providers and commercial payers. Hospital financial leaders will need to plan for the shifting of cost risk and volume risk from payers to hospitals in 2006. This trend will increase the burden on hospitals at a time when payers are already enjoying economic advantages relative to their provider counterparts. Although hospitals have seen a rise in commercial rates in 2005, many have also seen a steady decline in collections. Meanwhile, major insurers have recorded strong profitability, some reporting spending on medical care as low as 79 percent of total premium revenues.

Many hospital CFOs have responded to these trends with aggressive improvement initiatives to ensure payer contract compliance. They recognize the importance of organizational integration to achieve true best practices in the revenue arena.

For many CFOs, however, the questions remain: What specific payment trends and issues will require the most immediate attention in 2006? What should the organizational priorities be for improving contract performance?

**Key Payment Drivers**
Many of the issues and problems hospital CFOs will need to address in 2006 have been slowly emerging within their organizations and in the industry over many years. Before financial leaders can begin to set priorities among these issues and problems, they must reflect on the key payment drivers affecting the marketplace and understand the perspective of insurers.

Recently reported medical cost trends point to the top issues and their effects on payment performance:

- Overall spending on hospital care makes up nearly one-third of total healthcare spending. Payers are targeting hospitals in a major effort to minimize this expense.

- Twenty-eight percent of the $528 billion increase in healthcare spending from 1998 to 2003 is attributed to increased hospital spending. Payers are pursuing long-term deals with hospitals as a means to cap annual inflators.
- The hospital industry is experiencing rising costs of goods, workforce shortages, and greater demand for services. Hospitals will need to take a data-driven approach to guide decisions.
- The rate of increase in health insurance costs is expected to slow in 2006 for a third straight year because employers will continue to cut benefits and shift more costs to employees through consumer-directed health plans and/or higher coinsurance amounts in traditional plans, which will directly affect hospitals by increasing their burden for patient collections.
- Premiums for CDHPs rose 3.4 percent, on average, in late 2004 and early 2005, compared with 9.6 percent for all plans.
- Only 2.6 percent of employers currently offer CDHPs, but a much larger percentage have indicated they were considering doing so next year.
- Hospitals have largely overhauled their chargemasters over the past several years. Insurers are responding with defined caps on chargemaster increases.
- Hospital collections as a percentage of charges are tending to remain flat and in some instances, decreasing. Payers are placing the burden of “policing” payments on hospitals.

These trends indicate five areas that hospitals should regard as priorities to ensure they receive optimum payment in 2006.

**Payment Policing**
Auditing commercial payments will be the single most important job for many hospitals in the coming year. Payers have washed their hands of guaranteeing accurate payments and placed the burden of catching shortfalls on hospitals—and many hospitals are finding it difficult to rise to the challenge. Underpayments and denials continue to erode the bottom lines of U.S. hospitals. A recent survey shows that 8 percent to 14 percent of commercial revenue goes uncollected, and the number is much higher for hospitals that lack an effective audit function. Hospitals that are not vigilant face compounded difficulties, because payers also are narrowing the appellate window.

Although some hospitals already routinely monitor payment accuracy, many are only starting, and most have considerable room for improvement. Investment in auditing systems can prove effective. However, because of the complexity of contract terms and the general unwillingness of payers to fix underpaid or denied claims, hospitals also must devote considerable effort to ensuring that payers live by the terms negotiated.

Most standard contracts rule payments as final after a defined period of time (e.g., 365 days). Health plans have a legitimate reason for setting such limits, as it is unwise to operate with unknown liabilities. The process for resolving claim underpayments and denials, however, is cumbersome and often expensive, and providers must do all of the legwork, which can distract them from more mission-related activities.

These factors underscore the need for hospitals to establish formal audit programs. Too often, hospitals rely solely on patient financial services to pursue first- and second-level appeals. A coordinated approach involving a dedicated denial/underpayment management team, however, is more effective. Such an approach requires collaboration among patient access, case management, managed care, PFS, utilization management, and the medical director. The CFO should play a pivotal role by establishing performance standards, deadlines, and accountability. Managed care personnel should assist by providing summaries on key clauses related to each contract. Communication among team members should be regular, and standard performance reports should be created for tracking, monitoring, and resolving denials and variances.

**Action Steps**

- Assess the financial magnitude of the underpayment and denial problem to determine the percentage of commercial business that goes uncollected and the reasons for underperformance (including internal and external reasons).
- Define performance improvement standards and deadlines.
- Form a denial/underpayment management team with assigned responsibilities and regular performance reporting to the CFO.
- Create a monitoring tool or dashboard report.
- Routinely appeal all denials to preserve appellate rights.

**Contract Modeling and Data-Driven Organization**

In the competitive healthcare market, timely clinical, financial, and market data are necessary to guide strategic planning and decision making. Hospitals need to be armed with data to achieve positive financial outcomes in contract negotiations with commercial payers. Contract modeling plays a critical role in determining the success or failure of negotiations. This entails modeling the complex terms of the agreement, including carve-outs, high-cost items, the impact of outpatient grouper categories, and other contract-specific parameters. The analysis should use the previous year's data as input to model the impact of rate and payment methodology changes, including stop loss provisions as applicable.

Data-driven organization requires merging, analyzing, and using information to set the direction of the hospital. Hospital leaders should analyze financial and clinical data available in house on a timely basis and use these data effectively not only in negotiations with payers, but also in strategic analysis and planning. Only with timely information can senior management make the decisions that will ensure that the hospital achieves an optimal price and product mix.

**Action Steps**

- Create a contract modeling tool specific to each negotiation that enables the organization to project contract performance under multiple volume, price, and payment methodology scenarios.
- Use the modeling tool as a key means for deciding whether individual contract terms are acceptable.
- Develop sensitivity analyses to examine the financial impact of price and volume changes for key margin-driving services, such as surgery and imaging.

**Shift in Volume Risk**

In 2006, insurers are expected to aggressively shift volume risk to hospitals. Their primary approaches will be to introduce new payment methodologies and to focus on more aggressive management of specialty care.

*Shift to inpatient diagnosis-related groups or all-patient diagnosis-related groups.* Both health plans and hospitals are moving to the DRG payment methodology for their commercial business. Plans typically use Medicare's weights, but are becoming increasingly sophisticated under the commercial population APDRG weighting system.

The DRG system gives hospitals an opportunity to reduce denials resulting from length-of-stay utilization management enforced by payers under per diem contracts. However, before signing on with this methodology, hospital leaders should analyze their overall portfolio of business to make sure that DRG payment is appropriate for their organization (e.g., the DRG methodology may not be appropriate for large health systems that still have a high volume of percentage-of-charge payment) and that their case management is strong enough to keep costs within DRG payment limits.
Hospitals also need to negotiate the right base rate, taking into account stop loss provisions and "lesser of charges" language when transitioning from per diem to DRG payment. Assessment of stop loss, for example, requires a thorough analysis of first-dollar versus second-dollar payment and how outliers are defined in the agreement. This transition requires astute modeling to ensure that the contract performs at anticipated levels.

*Outpatient case category payment.* Utilization trends, complicated claims adjudication, and rising technology costs are leading health plans to overhaul their traditional outpatient payment methodologies and institute case category payment to achieve more predictable cost outcomes. This payment approach poses financial and administrative challenges for hospitals. For example, under a case category payment methodology, a payer's payment ranking system would group all services in connection with an emergency visit into one case rate. Thus, if a patient visits the emergency department and has a diagnostic test, the emergency case rate is still the only payment due under the new methodology.

This methodology can be risky to negotiate if the hospital does not have the modeling capabilities to fully analyze the impact to the bottom line. The complexity of these arrangements can leave management feeling that they negotiated good rates only to experience a declining revenue base several months later.

Effective modeling depends on the hospital's ability to analyze the payer's payment ranking system. Understanding the payment needed on a per case basis to cover the various service scenarios is critical to predicting the impact of this payment method and negotiating favorable rates. A single error in the financial modeling can lead to catastrophic revenue shifts.

*Specialty care management.* Managed care organizations will respond more aggressively in 2006 to rising specialty

care utilization trends. As consumer advocacy-based models of care management increase, health plans face increasing challenges in managing specialty care quality and cost. In the coming year, plans will more aggressively implement network strategies to steer members to low-cost providers, particularly in the areas of high-tech imaging and bariatric surgery. As a result of these strategies, traditional multiple service hospitals may see a decline in revenue in certain service areas as a result of increased competition from specialty care providers.

Traditional hospitals will need to pay close attention to volume and payment trends resulting from the competitive environment of ambulatory surgery centers, specialty outpatient centers, and specialty hospitals. As commercial payers become more sophisticated and focused with their specialty care management initiatives, provider markets will see real volume and price shifts.

**Action Steps**

- Perform an analysis to understand your hospital's preferred payment methodology for both inpatient and outpatient services.
- Assess the volume trends affecting your hospital and the market that are specifically related to patient steerage for diagnostics and other high-margin services.

**Shift in Cost Risk**

Insurers also will seek to shift cost risk to hospitals. Measures they are employing include setting limits on hospitals' chargemaster increases, eliminating stop loss coverage, and implementing new payment methodologies for high-cost drugs and implants and new technologies.

*Chargemaster limitations.* Health plans are limiting their risk for increased costs tied to chargemaster increases by negotiating language that allows them to adjust percentage-of-charge payment if the hospital's chargemaster increases by more than a defined percentage. Hospital negotiators need to be mindful of such language and negotiate either to remove this limitation altogether or, in situations where the hospital cannot remove the clause (for example, because of insufficient market leverage), to mitigate its impact by including a reasonable charge increase threshold.

*Elimination of stop loss coverage.* Health plans are attempting to push catastrophic case risk to hospitals, particularly under the DRG payment methodology. Hospitals that have high-cost cases need to be fully aware of the impact of waiving this coverage and identify such a provision as a potential "deal breaker," as appropriate.

*Payment for high-cost drugs and implants.* Payers are attempting to blend payment for high-cost drugs and implants into case payments on both the inpatient and outpatient side. Including high-cost drugs and implants in the case rate leads to easier claims adjudication, but it also increases the potential financial burden on the hospital. An alternate approach is for payers to pay implants based on cost plus a defined percentage. Although this approach seems reasonable in theory, it is impractical for hospitals because it requires them to submit invoices for individual cases. The approach has largely led to nonpayment for implants and contract underperformance, and thus should be avoided.

The ideal payment methodology for high-cost drugs and implants is payment based on a percentage of the hospital's charges. Under this approach, the hospital can agree that supplies exceeding a certain cost threshold (e.g., $1,000) and identified quarterly by name and specific revenue code will be paid as a percentage of charge, while lower-cost supplies will be paid as part of the case rate.

Payers are taking a hard line on this type of payment, however, and hospitals will need to weigh the benefits and risks of accepting the inclusion of implants and drugs in the case rates. In doing so, negotiators will need to ensure that they have identified the cost experience of the individual implants and drugs tied to each case so they negotiate the right price.

Negotiators also should seek protections in the contract for supply increases, and the hospital should have the right to reopen negotiations should technological advances or plan procedural changes have a significant financial impact on contract performance.

*Payment for new technologies*. Hospitals have traditionally reaped a less-than-favorable share of the economic benefit from advances in technology. They have been challenged to generate economic returns sufficient to keep pace with technology change and the demands of changing demographics.

Payers are increasingly focusing on cost-saving measures in this area, through either benefit design or provider payment. To be paid for new medical technologies, hospitals need to involve their managed care departments in the process for acquiring the technologies. Too often, hospitals purchase new technologies only to find during contract negotiations that the health plan will not pay for it.

To avoid such a scenario, the medical technology team should include clinicians, administrative leadership, and managed care, and finance staff. Physician involvement is critical to establishing clinical need and streamlining technology adoption, but it is equally important that physicians collaborate with other hospital decision makers who are equipped to explore financial and operational implications.

**Action Steps**

- During each contract negotiation, weigh the benefits and risks of accepting additional cost risk.
- Understand your costs specific to drugs, implants, and new technologies.
- Seek protections in the contract for supply cost increases.

**CDHPs, Pay-for-Performance, and Tiered Pricing**
The challenges posed by CDHPs, pay-for-performance, and tiered pricing will become increasingly interconnected in 2006, exerting greater pressure on hospitals to implement strategies and initiatives that effectively address each of these market factors.

CDHPs. Most immediately in 2006, hospitals will feel the increasing effects of CDHPs. Consumer-directed health care has grown rapidly, with 2.4 million members in 2005 and substantial increases expected over the next few years. CDHPs are an attempt by providers, employers, and payers to put health care into the retail world.

To a certain extent, most patients were never concerned about the cost of healthcare services, as they were responsible only for their coinsurance and deductibles. As CDHPs come to the forefront, there will be a need for price transparency, because patients will be making decisions that will directly affect their out-of-pocket expenses. An understanding of the true cost will prompt employees to talk to their physicians about less-expensive alternatives.

The benefits of CDHP for consumers are obvious:

- Plan coverage—CDHPs allow consumers to purchase coverage for services not typically covered by other benefit plans.
- Plan access—Barriers to access, such as referral mechanisms and verification of benefits, are minimal with CDHPs.
- Plan savings—The IRS's recent rule changes allow for a financial benefit of health savings account rollover.
- Choice—Consumer choices in health plans are much greater with the advent of CDHPs that go beyond the standard (e.g., EPO, HMO, POS, or PPO) offerings of employers.

The implications of this new generation of health plans for consumers are also obvious:

- Greater financial burden—CDHPs shift greater premium percentages to the consumer, having higher copayments, deductibles, and stop loss thresholds than traditional plans.
- Accountability for healthcare resource consumption—Some plans offer members rewards for lifestyle behaviors.
- Shopping for health care—Consumers are more saavy navigating resources to find the appropriate healthcare provider. Most payer web sites now have financial calculators to assist consumers in determining their cost.
- Record keeping—Consumers will need to track claims and payments for health care to account for their out-of-pocket costs. Although many of the CDHPs have tools for their members, this is a new burden for consumers to bear.

The employer benefits market is ready for consumer-directed health care as employers struggle to manage healthcare costs more effectively. With healthcare costs being their second largest expense (behind salaries), now more than ever, employers reevaluating how much they are willing to pay for healthcare coverage. If consumer-directed health care does not succeed in managing these costs, we may see a trend toward increased abandonment of employer-sponsored healthcare coverage.

*Pay-for-performance.* Pay-for-performance initiatives will become more prevalent in 2006. Hospitals are approaching payers' pay-for-performance initiatives with much caution. Senior leaders keenly remember failed risk contracting

efforts of the not-so-distant past, attributed in large part to hospitals' and payers' lack of any reliable means to measure the impact of quality on cost. In 2006, hospitals can expect payers to increasingly tie payment to specific quality indicators. Measurements and scoring formulas will likely be separated into three areas: patient safety, patient health outcomes, and patient satisfaction. Blue Cross Blue Shield explored such a pay-for-performance approach in 2005, but typically tied only a small percentage of annual payment increases to performance.

The ultimate result of pay-for-performance will be redesigned benefit plans that encourage members to use high-quality, lower-cost hospitals. Hospitals will need to embrace pay-for-performance in 2006 to ensure that they are moving toward measuring and demonstrating quality so that they can obtain their fullest possible competitive advantage in the marketplace.

*Tiered pricing.* Pay-for-performance will eventually result in tiered pricing, one way redesigned benefit plans will encourage members to use higher-quality, lower-cost hospitals. As an example, under tiered pricing, a member who has a surgical procedure performed at a lower-cost community hospital would have a lower copayment than he or she would have if the procedure were performed at a higher-cost specialty hospital, and the member's copayment might be even higher if the procedure were performed at an academic medical center. Tiered pricing thus shifts more financial responsibility for medical care benefits to the consumer and is an integral part of a CDHP.

Hospitals are tiered based on quality outcomes defined by the payers, which leaves considerable concern about the risk adjustment of data. The challenge for hospitals will be to ensure that payers use only timely and statistically valid data when assigning hospitals to different tiers.

Hospitals should be able to challenge the information provided by payers and question the integrity of the data as part of the process for determining appropriate payment. Further, hospitals should agree to put future payment increases at risk only when they are certain of the validity of the data and their ability to audit and provide input into the process.

**Action Steps**

- Educate physicians about pay-for-performance initiatives and the need to adhere to accepted standards of care.
- Form a pay-for-performance team, including appropriate physician leadership, that works directly with payers to understand and confer on the data and measurement parameters.
- Analyze revenue shifts resulting from higher patient responsibility and create an action plan for managing patient A/R more effectively.

**The Key to Success**

Commercial payment represents about 50 percent to 60 percent of a hospital's revenues. The payment environment of the past several years and leading into 2006 is dynamic. As hospitals face the mounting challenges of assuming increased risk and collecting more payment directly from consumers, their financial leaders will need to become increasingly proactive in their approach to managing this business. The hospitals that enjoy the greatest success will be those that are sufficiently data-driven, that have sufficient organizational integration, that effectively justify their pricing strategies, and that effectively manage their accounts receivables with patients and payers, on both the front and the back ends.

**More on Pay for Performance**

HFMA's Internet Guide to Pay-for-Performance Programs provides information on pilot pay-for-performance programs developed by healthcare consortiums and foundations that are exploring this approach. This resource includes links to information on each pilot program and numerous reports on pay-for-performance prepared by HFMA, the Health Lawyers Association, the Medicare Payment Advisory Commission, and other leading organizations. Go to www.hfma.org/resource/payperform.htm.

In Uninsured in America: Life and Death in the Land of Opportunity, published April 2005 (The University of California Press), Susan Sered and Rushika Fernandopulle use results of 120 interviews with uninsured men and women and dozens of medical providers, policymakers, and healthcare advocates to provide insight into the problem of America's more than 40 million uninsured and explore its implications for American society.

To find out more about this book and its underlying research, go to The Commonwealth Fund web site at www.cmwf.org, click on "Health Insurance," select "Latest Publications," and scroll to "Profiles of the

Uninsured" under "Other Resources."

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