



Beyond Benchmarking: Provider, Payor, & Price Transparency Data Usage Strategies

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Agenda

1. Industry Trends
2. Current Transparency Landscape
3. Price Transparency Data
4. Price Strategy Including Market Position
5. Rate Benchmarking
6. Managed Care Playbook
7. Payment (Variance) Strategy
8. Next Steps

Industry Trends



Hospital & Health System Challenges

- **New Administration's Focus on Price Transparency Compliance**
- Labor shortages & increased costs
- Continued inflation
- Margins remain lower than pre-COVID levels

Figure 1. Labor constitutes largest percentage of hospital expenses.

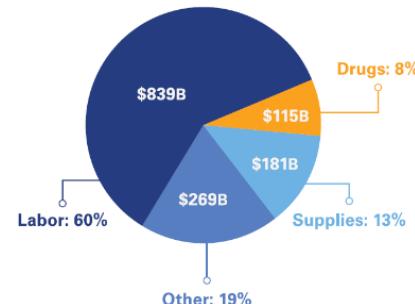


Figure 4. Hospital payments do not cover the costs of providing vital inpatient services

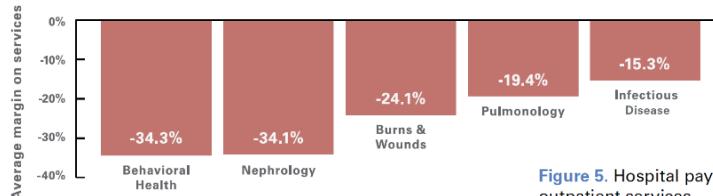


Figure 5. Hospital payments also fail to cover the costs of providing essential outpatient services

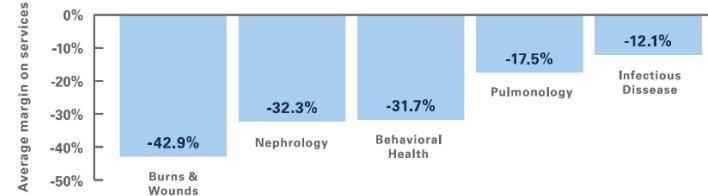
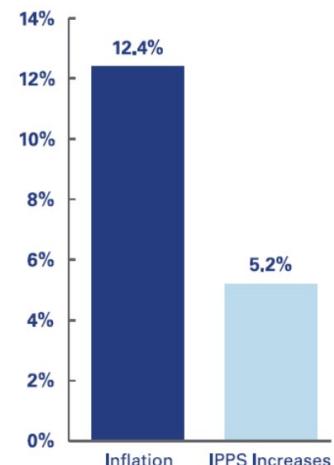


Figure 2. Inflation growth was more than double the growth in IPPS reimbursement, 2021 - 2023

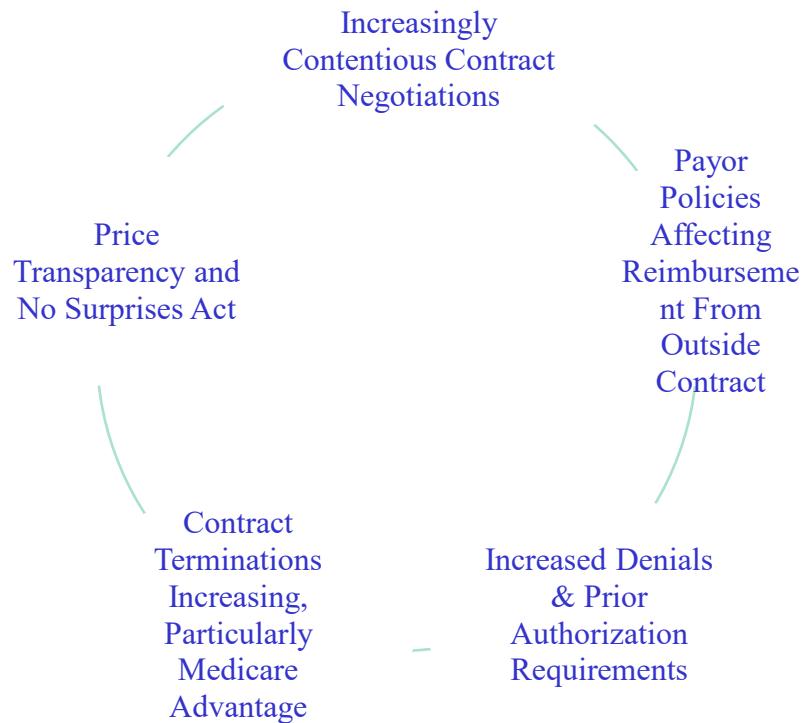


Source: America's Hospitals and Health Systems Continue to Face Escalating Operational Costs and Economic Pressures as They Care for Patients and Communities, aha.org

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Payor/Provider Relationships



HEALTH

Medicare

Hospitals, doctors drop private Medicare plans over payment disputes

 **Ken Alltucker**
USA TODAY

Published 3:52 p.m. ET Oct. 27, 2023 | Updated 4:30 p.m. ET Oct. 27, 2023

HOSPITALS, MEDCITY INFLUENCERS, PAYERS

Payer Negotiations Are Getting Ugly

As margins at health systems continue to contract, and insurance company profits continue to surge, contract negotiations are becoming increasingly contentious. With billions of dollars potentially at stake, you need to be prepared and aligned well in advance.

REIMBURSEMENT NEWS

Private payers initially deny nearly 15% of medical claims

Financial Management

15 health systems dropping Medicare Advantage plans | 2024

Image sources: USA Today, MedCity News, TechTarget, Becker's Hospital Review

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Cost of Healthcare



Pressure to Control Increasing Costs

- Employers
- Consumers
- Governmental



Focus on Value

- Care management programs
- Steerage efforts
- Growth in population health programs & value-based care



Site-of-Service Shifts

- Inpatient to outpatient
- Ambulatory & freestanding providers
- In-person care vs. virtual

Current Transparency Landscape



CMS Transparency in Coverage Ruling



Effective January 1, 2021, **hospitals** were required to publish negotiated rates with all payors.

- Historically confidential information
- Limited services provided in a consumer-friendly format; “machine-readable file” (MRF) of all services



Effective July 1, 2022, **payors** were required to publish negotiated rates for all provider types.

- Hospitals plus physicians, ASCs, post-acute facilities, etc.
- Phased rollout; all services now required to be published



Effective February 25, 2025, **executive order** on hospital price transparency compliance

- Federal government’s focus on price transparency compliance including additional audits and potential fine levees

Lifting the Veil

The availability of Price Transparency data is intended to unveil previously proprietary pricing between providers and payors. The data will create internal and external market disruption:



Health Plans/Payors will utilize the published pricing to ascertain whether the rates they have with providers are in line with rates negotiated with other insurers.



Providers will utilize the published pricing to compare themselves to their peers and among each of the health plans to drive their strategic pricing initiatives and approach to managed care.



Employers armed with competitive pricing from hospitals and payors may elect to develop steerage mechanisms to encourage employees to utilize **lower-cost** hospitals.



Informed consumers will have the ability to shop rates among hospitals and health plans.

Price Transparency in Action

“[We] **conducted a thorough review** of [your] cost position both [with us] and amongst other payers [...] this data indicates that both **Cigna and [United Healthcare]** are **benefitting from materially more favorable rates** at your facility by up to 15%. These results are **exceptionally troubling**, especially given the significant market share that Anthem brings to [you], our longstanding relationship, as well as our collective efforts to address the cost of care for consumers through value-based care arrangements.”

Anthem

Anthem offered **-8% decrease** in rates

Provider received **+33% increase** to orthopedic reimbursement

“Based on our review of your published price transparency files, we’ve determined that **our facility is not receiving a fair rate** for orthopedic services. The negative revenue impact of these rates is substantial for our facility and **no longer supports the provision of these services** to your members.”

Managed Care Director

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Price Transparency Data

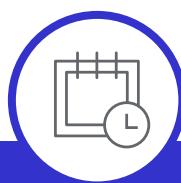


Limitations With the Hospital Machine Readable Files

2024 CMS requirements aim to improve accessibility by standardizing the format in which hospitals disclose negotiated rates. However, limitations persist in extracting meaningful data from these files:



Incomplete; hospitals only mandated to publish rates for services for which they have a standard charge



Updates only required annually



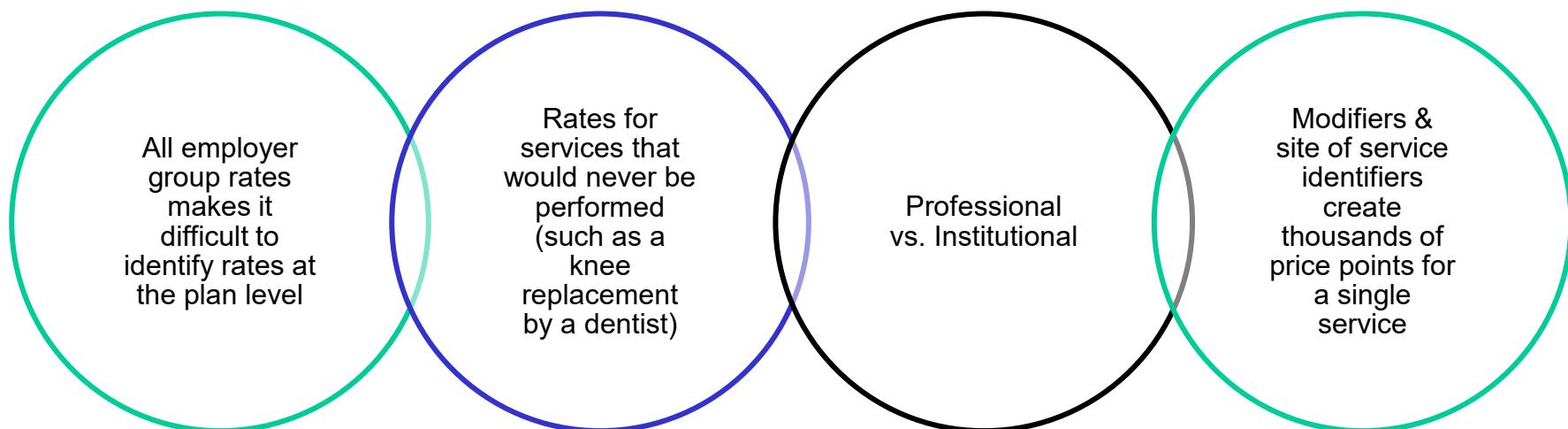
Other provider types exempted from the Rule



Standardization not enforced until July 1, 2024, prolonging usability timeline due to expected delays in compliance

Challenges With the Published Payor Files

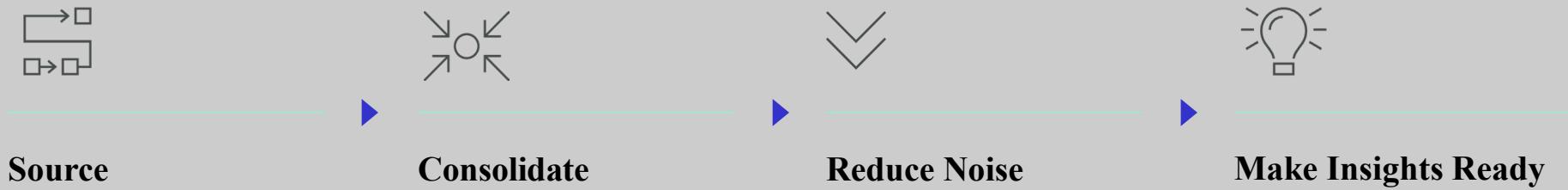
Payor data and formatting requirements are more standardized than for hospitals. However, the files include terabytes of data and payors have included millions of extraneous data points such that the files are nearly impossible for an average user to access, let alone interpret.



Data Solution

Forvis Mazars utilizes a platform for exploration of payor price transparency MRFs:

- Server able to digest payor files, which can be terabytes in size
- Reduction of ghost rates & irrelevant plans; enriches data for easier discovery
- Analytical consolidation of data across payors, markets, & other meaningful data points
- Forvis Mazars managed care team overlays existing framework to develop business ready insights



Price Strategy Including Market Position



Price Strategy/Methodology

Case Studies (on Market Position & Strategic Pricing)

Price (Charge) development to support annual budgetary process to estimate gross & net revenue price change impacts for hospital & physician group procedures, medical supply & Rx.

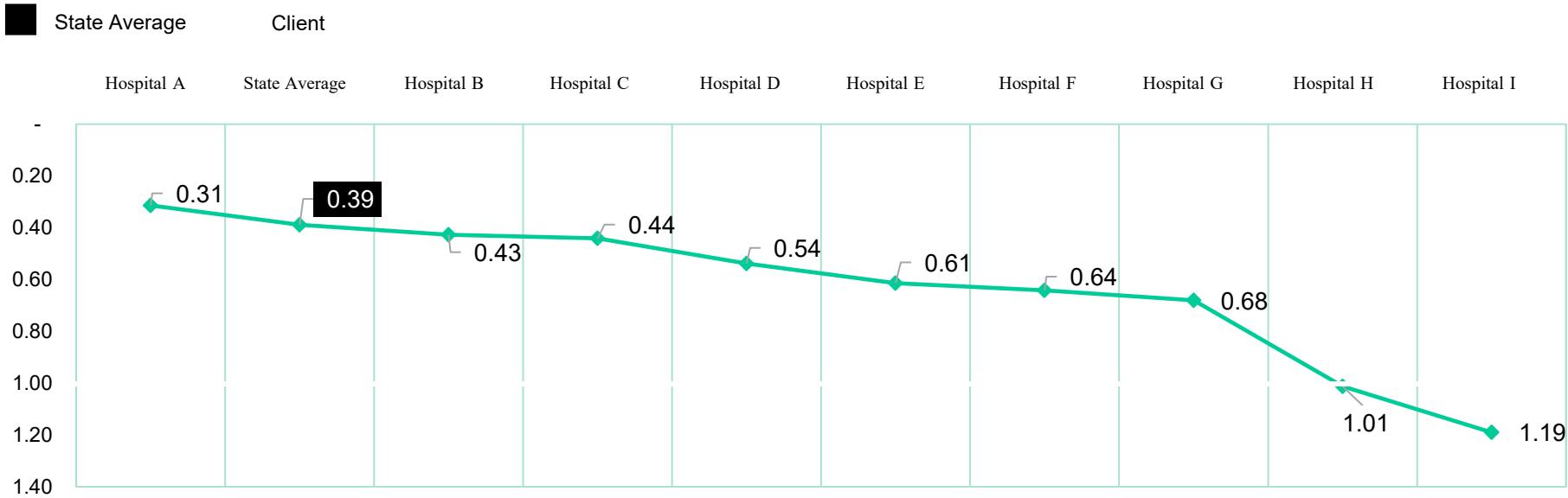
Data Collection	Market Position	Model Build	Scenario Refinement	Rational Price
<ul style="list-style-type: none">CDMRev/UsageClaimsFinancial StatementsContracts w/SupplementsPayerset	<ul style="list-style-type: none">Peer AnalysisLeadingMiddleTrailing	<ul style="list-style-type: none">Hospital (Procedure, Medical Supply & Pharmacy)Clinics	<ul style="list-style-type: none">Strategic PricingLesser ThanMultiple of Payor (Public/Private)	<ul style="list-style-type: none">RelationalLevels
Data Collection & Validation	Understand Position	Financial Impact	Price Strategy	New Prices
Work with clients to collect, validate, & reconcile data to support work product	How do my prices compare to peers in my geography, market, specialty?	Build Pricing Model – strategic, cost based, lesser than; calculate gross & net benefits	Develop defensible price strategy & aggregate results by payor a&depts	Provide uploadable file for implementation into production



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Overall Sample Hospital

How do my prices compare?



- Client's gross charges are X amount of the Competitor's gross charges
- Client is priced below 8 competitor facilities (including the state average) and above 2 competitor facilities.

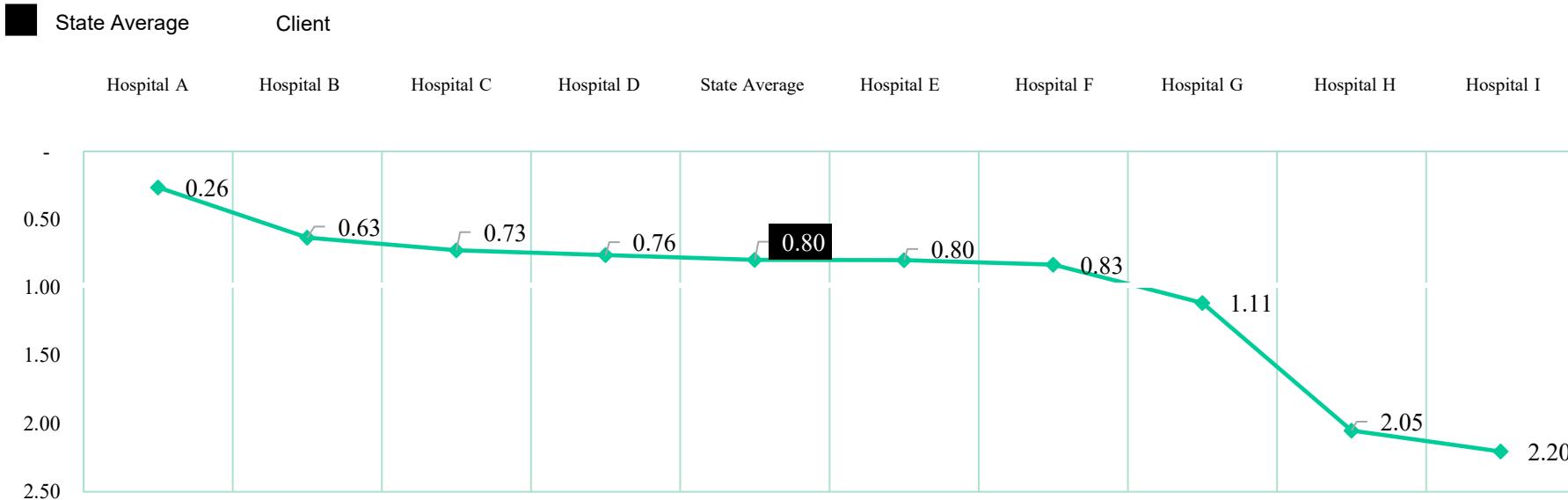
Data Source: Forvis Mazars sample client data, anonymized for confidentiality

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Department Specific

Radiology



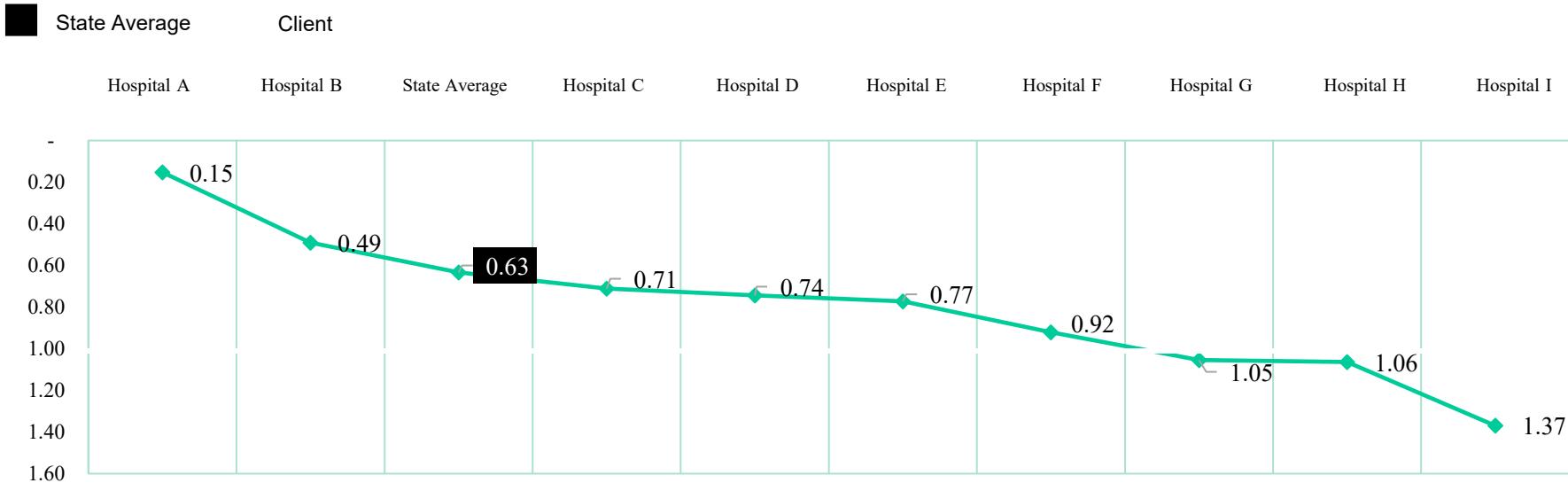
- Client's gross charges are X amount of the competitor's gross charges
- Client's department Radiology is priced below 7 competitor facilities (including the state average) and priced above 3 competitor facilities

Data Source: Forvis Mazars sample client data, anonymized for confidentiality

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Department Specific Laboratory



- Client's gross charges are X amount of the competitor's gross charges
- Client's department Laboratory priced below 7 competitor facilities (including the state average) and priced above 3 competitor facilities

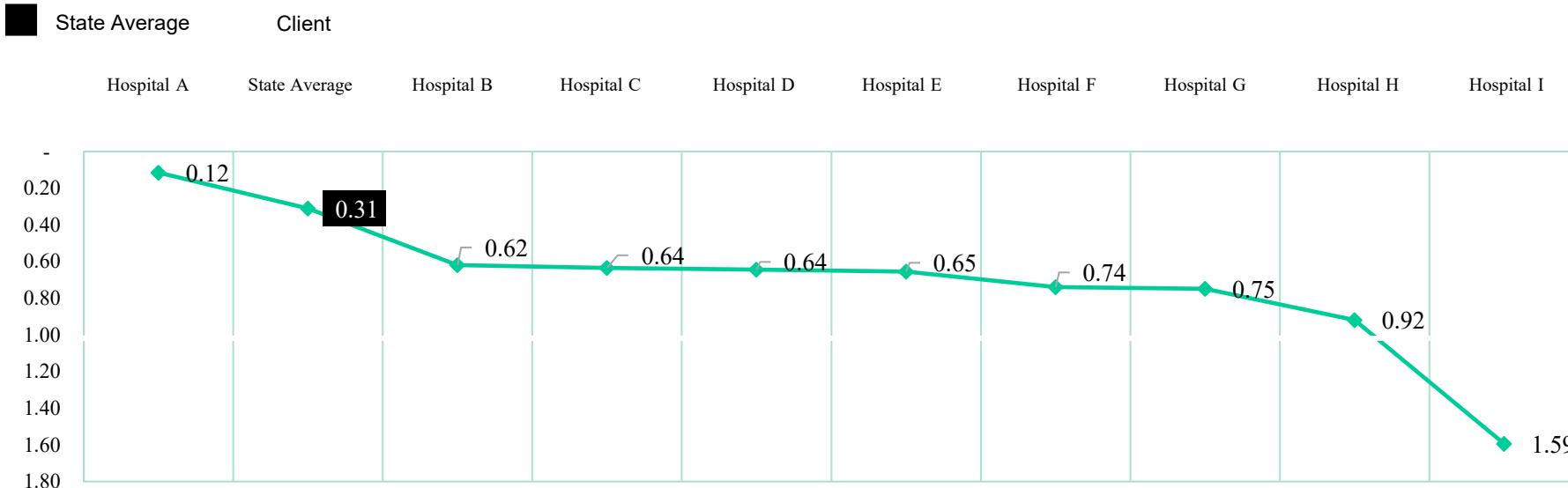
Data Source: Forvis Mazars sample client data, anonymized for confidentiality

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Department Specific

Pharmacy



- Client's gross charges are X amount of the competitor's gross charges
- Client's department Pharmacy is priced below 9 competitor facilities (including the state average) and priced above 1 competitor facility

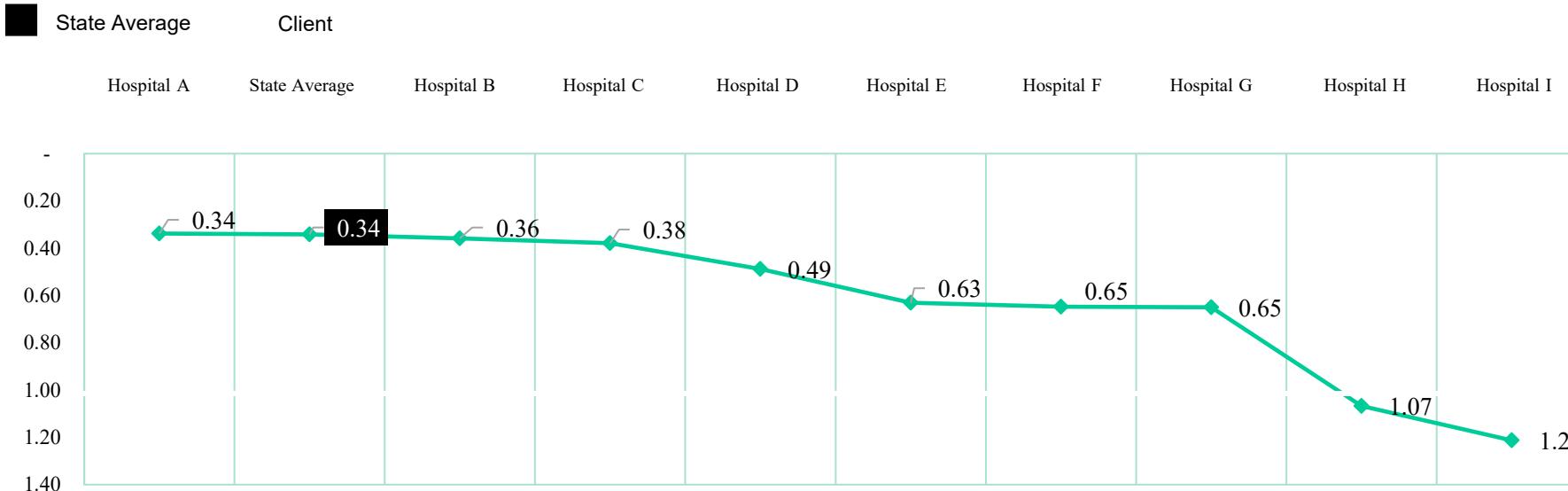
Data Source: Forvis Mazars sample client data, anonymized for confidentiality

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Department Specific

Surgery (Represents Supplies & Implants)



- Client's gross charges are X amount of the competitor's gross charges
- Client department Surgery is priced below 8 competitor facilities (including the state average) and priced above 2 competitor facilities

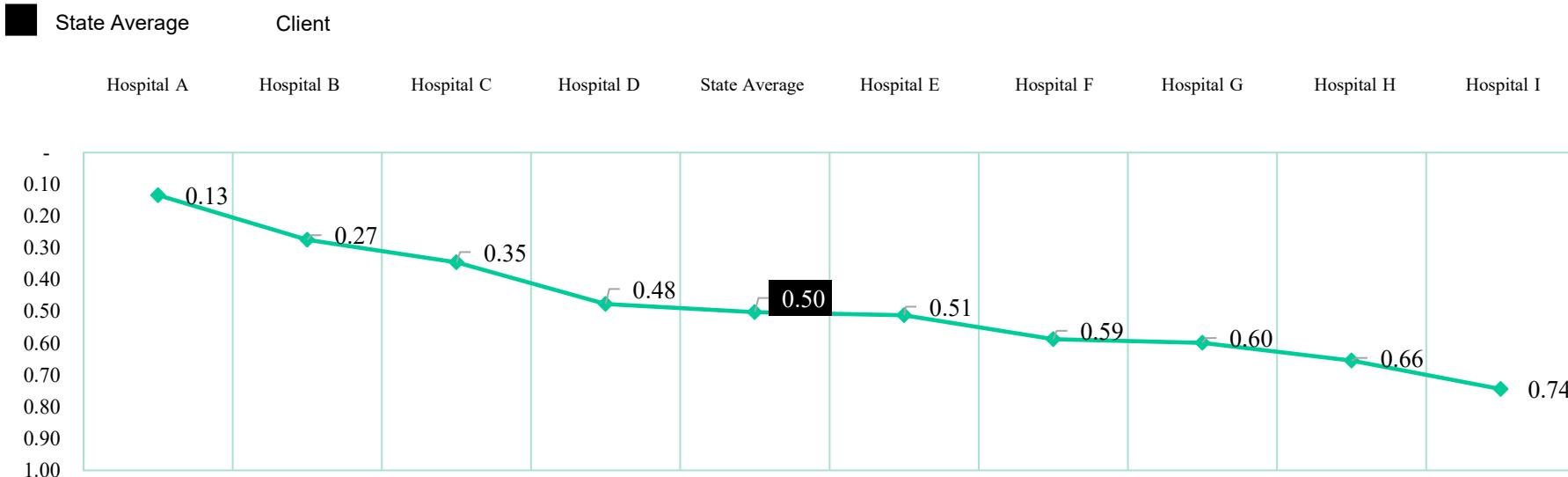
Data Source: Forvis Mazars sample client data, anonymized for confidentiality

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Department Specific

Emergency Room



- Client's gross charges are X amount of the competitor's gross charges
- Client's department Emergency Room is priced below 10 competitor facilities (including the average)

Data Source: Forvis Mazars sample client data, anonymized for confidentiality

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Hospital Revenues by Gross/Net Opportunity

Sample Hospital

Total Revenues With Net Margin Contribution Opportunity

Total Hospital Gross Revenues:	\$1,036,243,030
Total Hospital Gross Revenues With Fixed Reimbursement:	\$957,864,442 (92.44% of Total Hospital Gross Revenues)
Total Hospital Gross Revenues With % of Charge Reimbursement:	\$78,378,588 (7.56% of Total Hospital Gross Revenues)
Hospital Gross Revenues Removed From % of Charge Reimbursement Due to Contractual Carve-Outs:	\$27,988,984 (2.70% of Total Hospital Gross Revenues)
Hospital Gross Revenues With % of Charge Reimbursement Applied:	\$50,399,604 (4.86% of Total Hospital Gross Revenues)
Net Margin Contribution:	3.85% (\$39,919,229 Net Impact)



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Hospital Contractual Reimbursement

Sample Hospital

Payor/Plan Grid With Reimbursement Methodologies & Carve-Outs

Payor/Plan	Total Model Payor Mix	IP Reimbursement Methods	OP Reimbursement Methods	OP Carve-Outs
Payor 1	0.08%	81.50%	81.50%	
Payor 2	7.36%	0.00%	85.76%	RC 61x, RC 401, 403, RC 35x
Payor 3	0.41%	0.00%	60.00%	Medicare CLFS (CPT 80000-89999 AND RC 300-319)
Payor 4	0.08%	95.00%	95.00%	
Fixed	90.88%	0.00%	0.00%	
Payor 5	0.05%	0.00%	53.96%	CPT 80000-89999 and CPT 70000-79999
Self-Pay	0.68%	5.00%	5.00%	
Payor 6	0.47%	0.00%	71.20%	

- All R&U Financial Class & Primary Insurance plans mapped to Payor/Plan based on reimbursement methodology. Some payors/plans mapped to Fixed due to minimal impacts, *i.e.*, Workers Compensation, and to support conservative estimates (Employee Health).

- Annualized Revenues July 2023 – June 2024



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Hospital Procedure Pricing Model

Notes

Sample Hospital

Price Strategy	Definition	Included in Model
Medicare Fee Schedule (@ X% multiple)	Priced above Medicare	Yes
Lesser Than Commercial Fee Schedules (Payor 2, 3, & 5)	Priced above Available Commercial Fee Schedules	Yes
Static Pricing	Any direct-to-employer negotiated rates or known consumerism CDM codes	Yes
Rounding	Sample Hospital's methodology to round all pricing up to nearest dollar and or fifty cents	Yes
Rational Pricing	Relational pricing – levels, same CPT in multiple departments	Yes
Revenue Codes or Categories	Known consumerism Revenue Codes	Yes
Market Position	Known consumerism CDM codes	Yes

Hospital Procedure Pricing Model

Scenarios

Sample Hospital

Total Revenues with Net Margin Contribution Opportunity

Notes	Scenario	Any Contractual Cap Exceeded?	% Change Gross Payors	% Change Net Payors	Adjusted Net \$ Pickup (After Take-Back)	Adjusted Net \$ Gain (After Take-Back) Minus 5% ATB
	5% ATB	Yes	5.15%	5.14%	\$927,016	
	Scenario 1	Yes	1.99%	5.64%	\$1,712,912	\$785,897
	Scenario 2	Yes	2.66%	6.45%	\$2,175,063	\$1,248,048
Lowest Take-Back Amount	Scenario 2a	Yes	2.48%	5.87%	\$2,111,978	\$1,184,962
	Scenario 3	Yes	3.37%	5.72%	\$1,784,646	\$857,631
	Scenario 3a	Yes	3.38%	5.66%	\$1,781,983	\$854,968
Largest Yield	Scenario 4	Yes	2.50%	7.42%	\$2,397,975	\$1,470,960
	Scenario 5	Yes	3.40%	6.16%	\$1,740,686	\$813,671
Largest Yield, Staying Under 5% Payor Notification	Scenario 6	Yes	3.54%	6.19%	\$1,812,177	\$885,162

ATB = Across the Board
 Adjusted Net \$ Pickup = Change Net \$ - Total Take-Back Amount
 Adjusted Net \$ Pickup minus 5% ATB = Adjusted Net \$ Pickup - 5% ATB
 Take-Back Amount Calculation for all payors



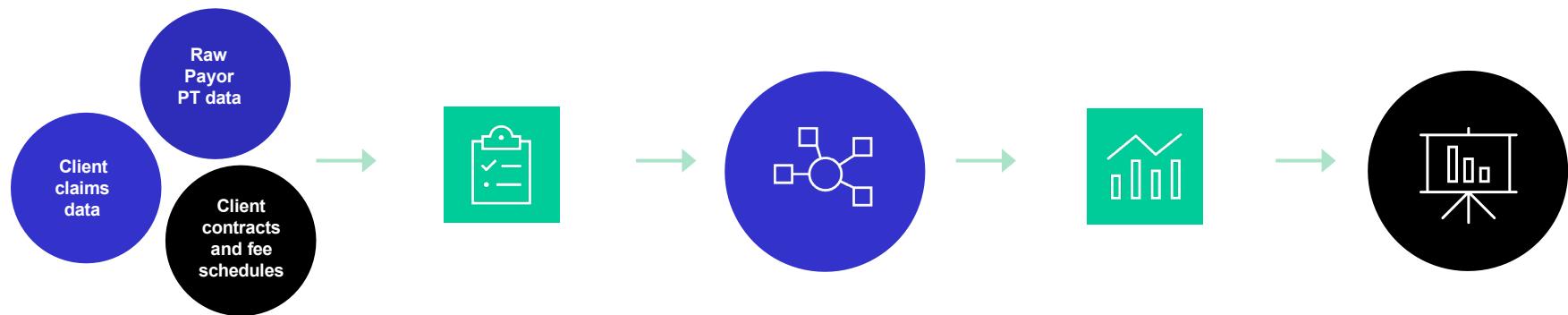
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Rate Benchmarking



Rate Benchmarking

Methodology



Source

Access raw data from Payor Price Transparency files, client commercial claims data for top payors, & current contracts & fee schedules

Validate

Summarize key data statistics, e.g., payor mix, case mix, and validate receipt of all necessary elements from client

Normalize

Standardize service line mapping, identify focus areas, refine Payerset data, define benchmark parameters, & identify any assumptions & limitations

Benchmark

Identify pricing tenets for comparison, create & apply benchmarks, & aggregate results by payor & service line

Summarize

Summarize observations that will inform recommendations

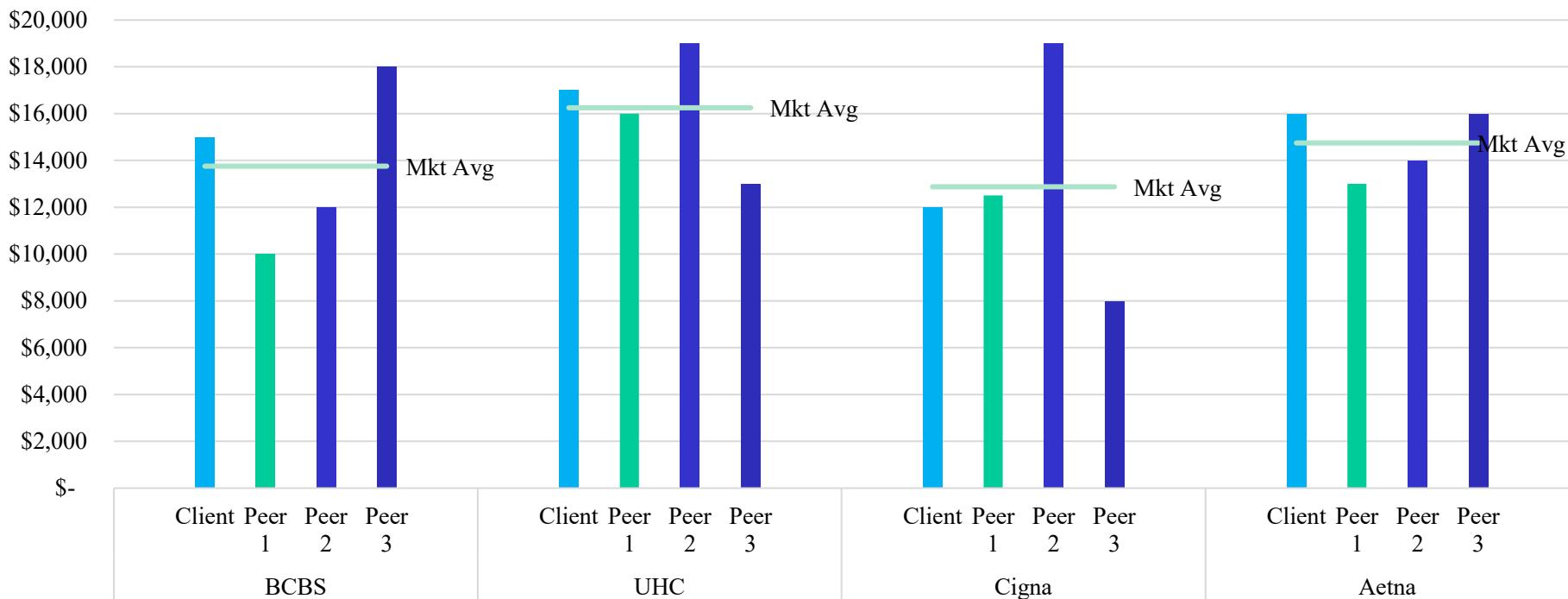
Negotiated Reimbursement by Payor

High level view of provider's payor-specific aggregate negotiated rates as compared to chosen market peers. Results are shown as a % variance relative to each peer.

Payor	Peer 1	Peer 2	Peer 3	Market Average
BCBS	+15%	+30%	-10%	+10%
UHC	-18%	+12%	-4%	-5%
Cigna	+26%	+17%	-8%	+18%
Aetna	-10%	+7%	-19%	-7%

Inpatient

The graph below shows a client's payor-specific rates relative to peers for inpatient services, shown here as weighted average case rates. The market average by payor has also been graphed.



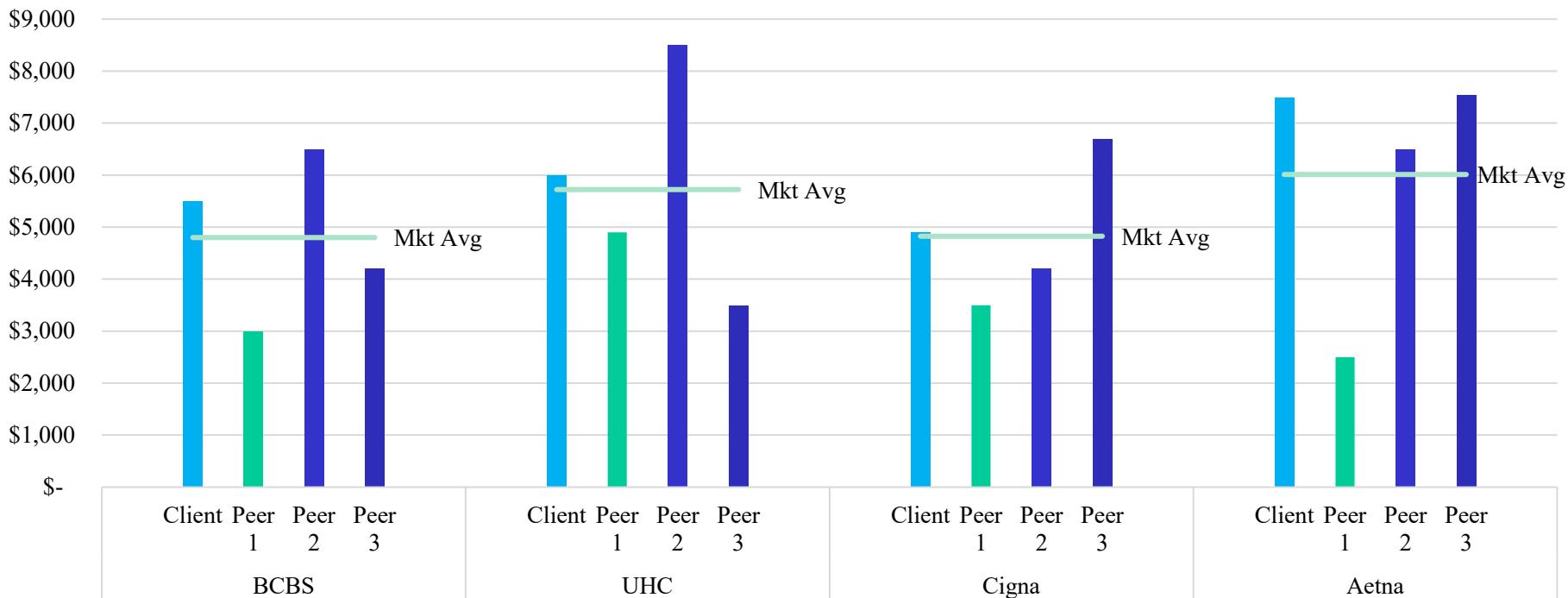
Data Source: Forvis Mazars sample client data, anonymized for confidentiality

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HOPD Surgery

The graph below shows a client's payor-specific rates relative to peers for HOPD Surgery services, shown here as weighted average case rates. The market average by payor has also been graphed.



Data Source: Forvis Mazars sample client data, anonymized for confidentiality

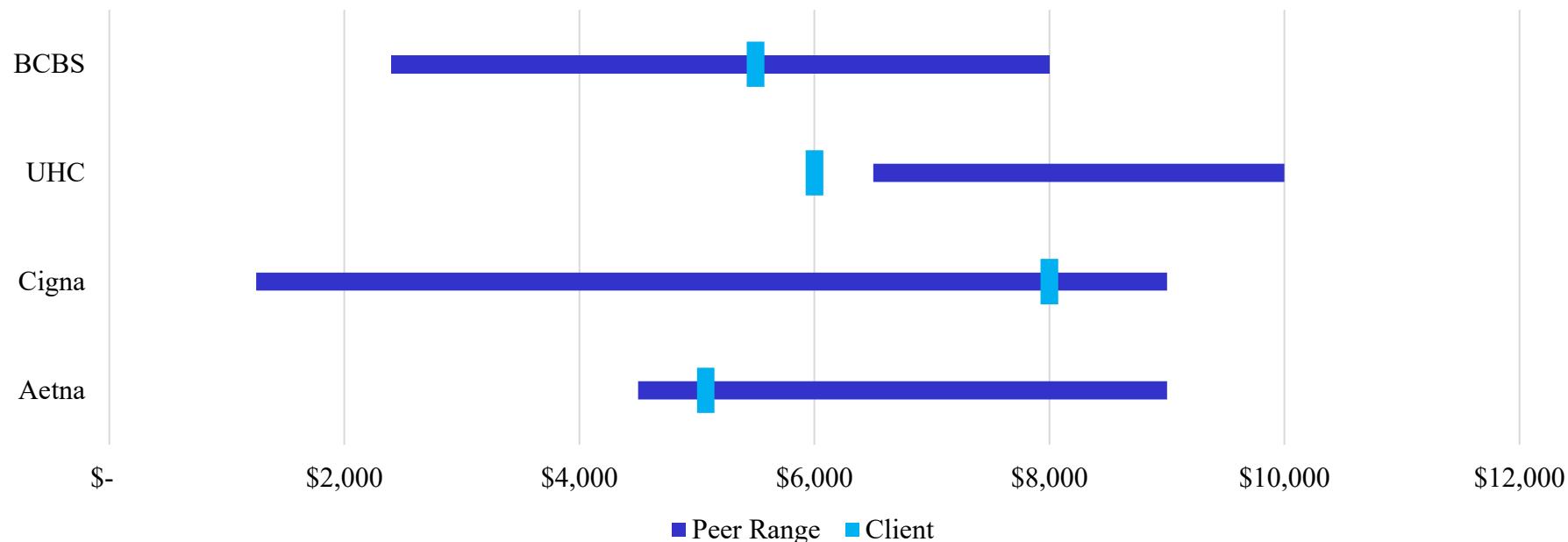
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HOPD Surgery

Total Knee Replacements

Drilling down to a specific service or single procedure level, this graph highlights client pricing for total knee replacements relative to the market range.



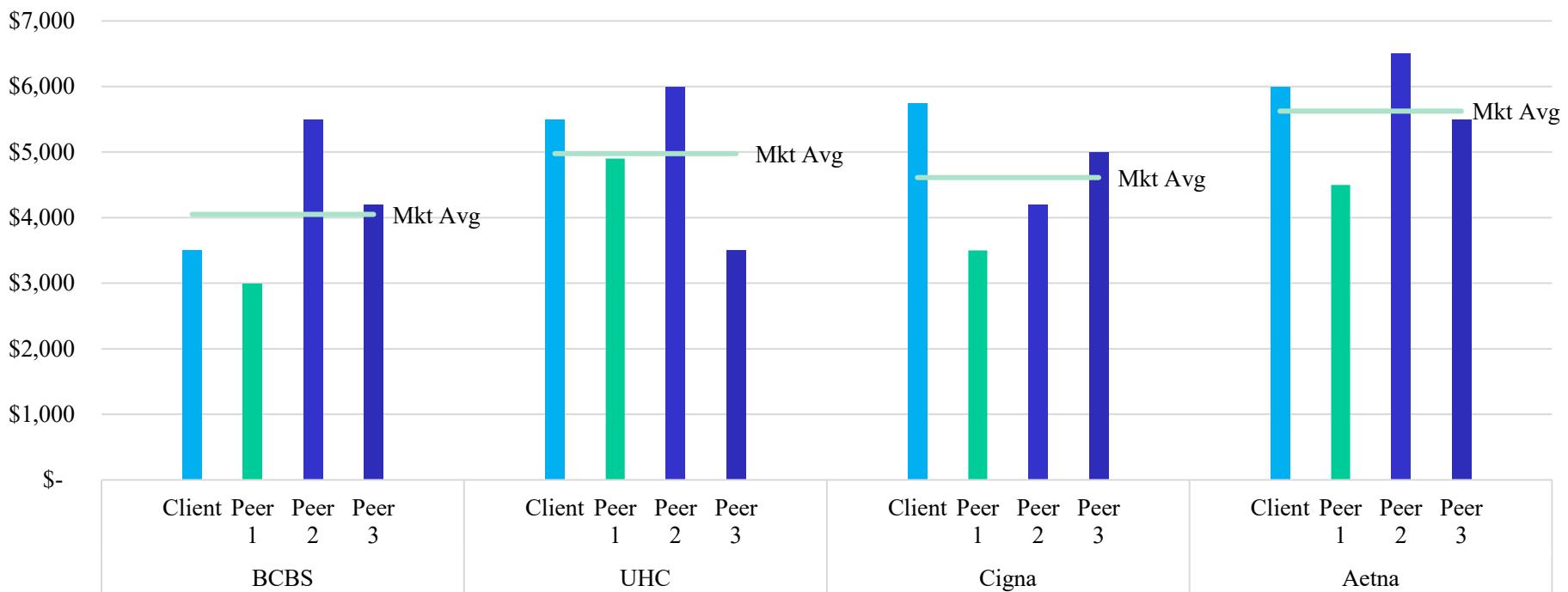
Data Source: Forvis Mazars sample client data, anonymized for confidentiality

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Emergency Department

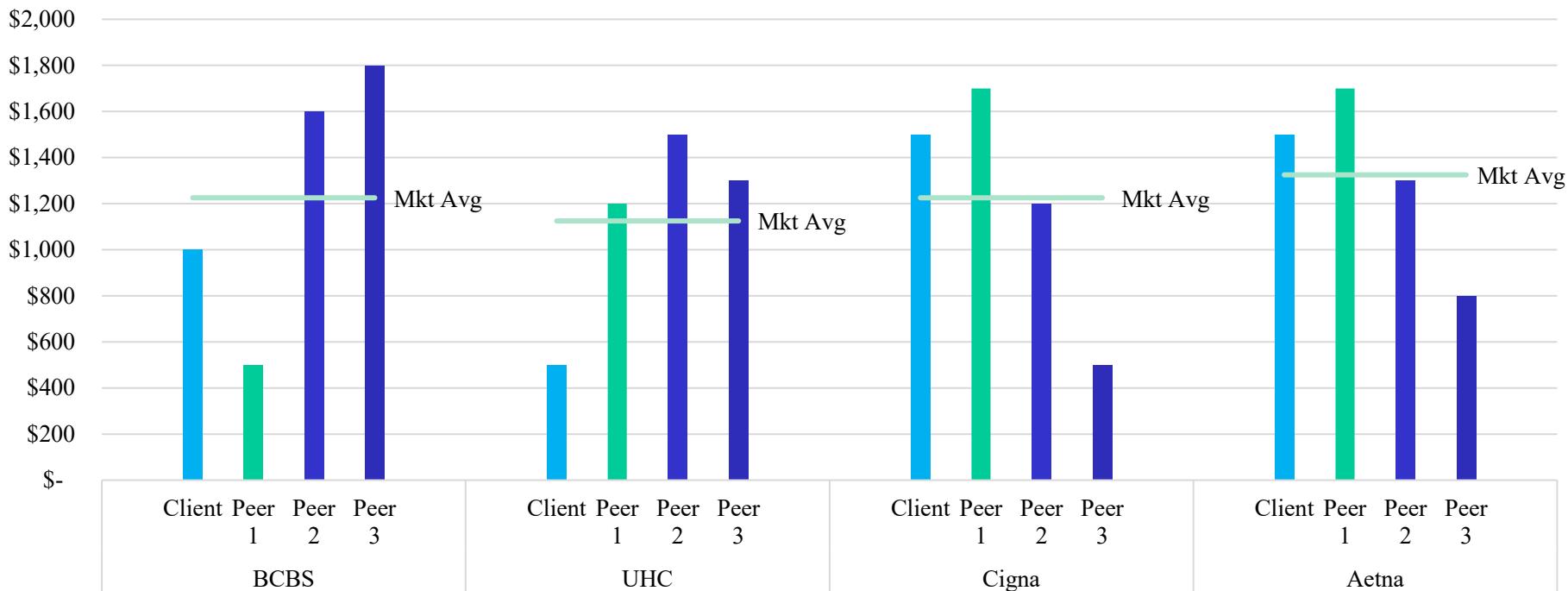
The graph below shows a client's payor-specific rates relative to peers for Emergency Department services, shown here as weighted average case rates. The market average by payor has also been graphed.



Data Source: Forvis Mazars sample client data, anonymized for confidentiality

Imaging

The graph below shows a client's payor-specific rates relative to peers for imaging services, shown here as weighted average case rates. The market average by payor has also been graphed.

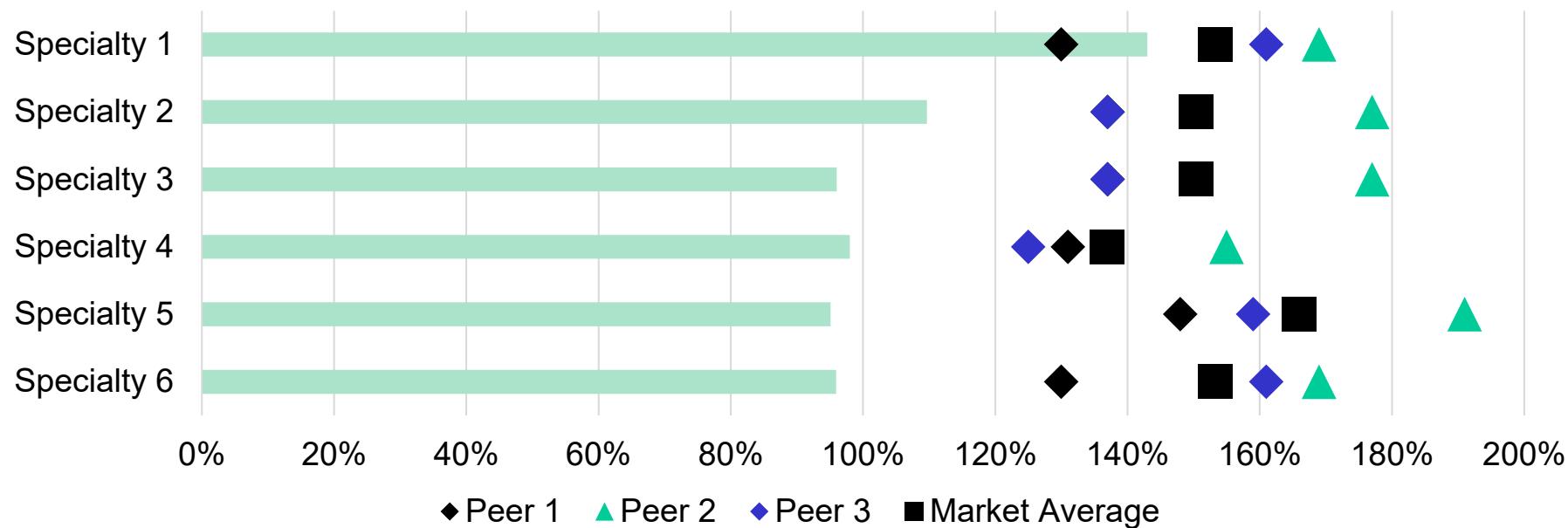


Data Source: Forvis Mazars sample client data, anonymized for confidentiality

Physician Benchmarking

BCBS

The graph below displays a client's pricing performance relative to peer benchmark and market benchmarks by specialty as a percentage of CMS, e.g., primary care, orthopedics, etc.



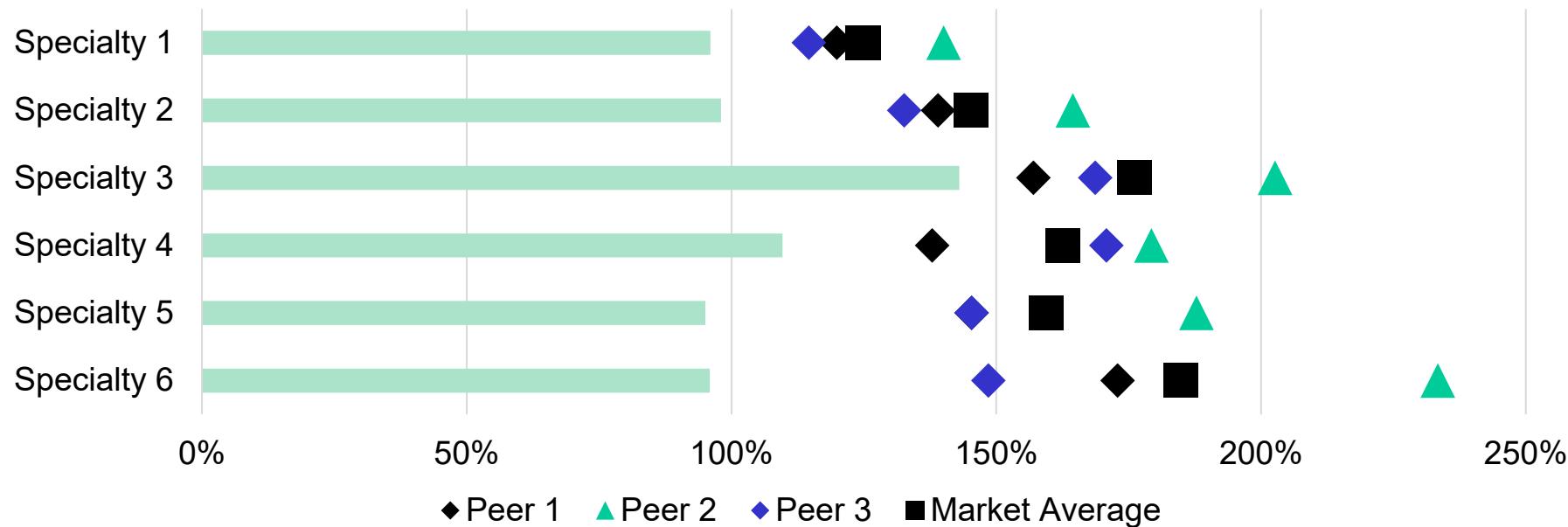
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Physician Benchmarking

UHC

The graph below displays a client's pricing performance relative to peer benchmark and market benchmarks by specialty as a percentage of CMS, e.g., primary care, orthopedics, etc.



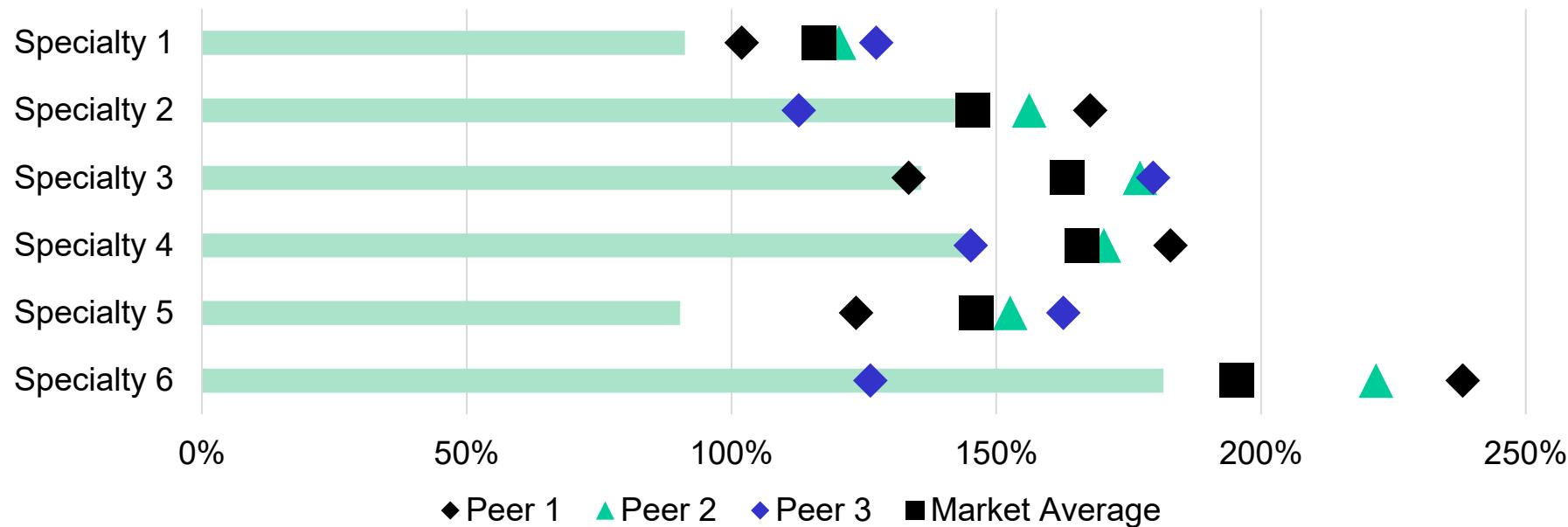
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Physician Benchmarking

Cigna

The graph below displays a client's pricing performance relative to peer benchmark and market benchmarks by specialty as a percentage of CMS, e.g., primary care, orthopedics, etc.



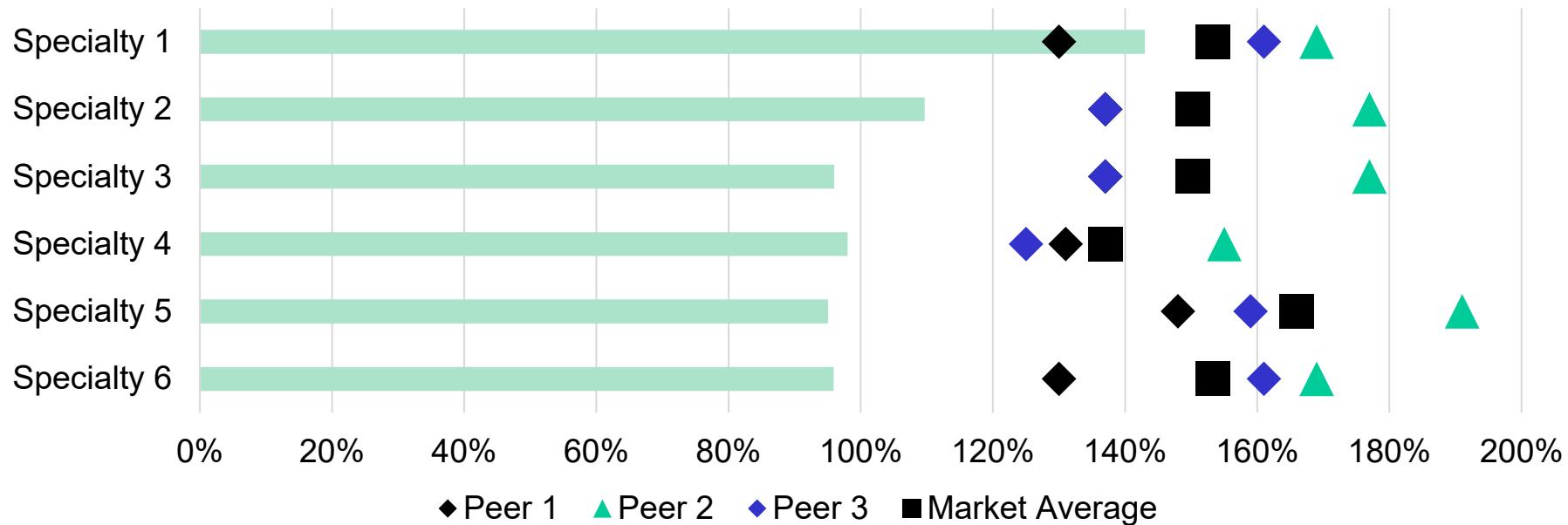
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Physician Benchmarking

Aetna

The graph below displays a client's pricing performance relative to peer benchmark and market benchmarks by specialty as a percentage of CMS, e.g., primary care, orthopedics, etc.



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Managed Care Playbook



Action Plan

Multi-Year Approach

Based on the findings from an Assessment and Rate Benchmarking scopes of work, Forvis Mazars will create an Action Plan tailored to the client's organizational strategies and initiatives by each payor and service line, where applicable:

Priority	Negotiation Approach	YEAR 1	YEAR 2	YEAR 3+
1 BCBS	<ul style="list-style-type: none">Shift dollars from IP to OP allowables			
2 Cigna	<ul style="list-style-type: none">Review and renegotiate IP rates for certain services with carve-outs			
3 Aetna	<ul style="list-style-type: none">Negotiate stronger ED rates to be competitive within the market			
4 ASC	<ul style="list-style-type: none">Multi-payer strategy that accounts for the shift of site-neutral payments			
5 Ancillaries	<ul style="list-style-type: none">Multi-payer strategy to offset allowables and reduce rates to compete with free-standing options			

Payor Evaluation

Risks & Opportunities

Forvis Mazars will utilize Rate Benchmarking detail, payor-specific trends, and market detail to highlight Risks & Opportunities for consideration during the negotiation process.

Risks



- Cigna imaging rates fall well above larger payors; consider steerage potential
- Commoditized procedures exceed peer rates across payors, *e.g.*, colonoscopies
- Opening physician contract negotiations may result in payor pressure to open favorable facility contracts for negotiation as well

Opportunities



- Physician rates fall well below peer & market average rates across payors & specialties
- Consider strategic CDM increases to optimize Aetna percentage of charge reimbursement
- Consider adding implant reimbursement or procedure carveouts where high-cost implants are used

Contract Language

Key Terms

Legend

- ✓ Meets recommendations
- Improvement recommended
- No existing language

Contract Term	BCBS	UHC	Cigna	Aetna
No network pricing mandates	●	●	--	--
Protection against material policy changes (\$ threshold or requiring advance notice)	●	●	--	--
Requires mutual agreement to add additional products	●	✓	●	●
Sufficient claims submission timeline (at least 90 days)	✓	✓	✓	✓
Clear prompt payment of claims (30-45 days)	●	✓	●	●
Parity in retrospective payment adjustments w/reasonable timeframes (6-18 mos.)	✓	✓	--	--
Without cause termination 60-120 days (ideally, not tied to anniversary date)	●	●	✓	✓
Reasonable timeframe to return overpayments prior to offset (>60 days)	✓	●	--	--
Unilateral assignment by payor not allowed (require mutual agreement)	●	●	●	●
Amendments require mutual agreement between parties (not unilaterally by payor)	●	✓	✓	✓
Charge master notice requirements not overly burdensome (only req. net impacts)	✓	●	✓	✓
Reference Provider's 'billed charges' rather than 'usual and customary' charges	✓	●	✓	✓
No rate penalties permitted against provider	✓	●	●	●
New services paid by default rate rather than requiring separate negotiation	--	✓	●	●
Revenue neutral CMS updates	--	--	--	--

Financial Projections

Current & Future State

Forvis Mazars will develop Financial Projections based on upcoming negotiation cycles. Financial projections will utilize rate benchmarking detail, payor negotiation experience, and current market trends to highlight the potential financial opportunity range defined by payor and service line.

	BCBS	UHC	Cigna	Aetna	Total
<u>Inpatient</u>	\$ 5,000,000	\$ 4,300,000	\$ 2,750,000	\$ 2,400,000	\$ 14,450,000
<u>Outpatient</u>	\$ 10,000,000	\$ 9,600,000	\$ 9,120,000	\$ 8,208,000	\$ 36,928,000
Emergency Department	\$ 1,000,000	\$ 920,000	\$ 874,000	\$ 786,600	\$ 3,580,600
HOPD Surgery	\$ 3,000,000	\$ 2,760,000	\$ 2,622,000	\$ 2,359,800	\$ 10,741,800
Imaging	\$ -	\$ 400,000	\$ 380,000	\$ 342,000	\$ 1,122,000
OP Other	\$ 6,000,000	\$ 5,520,000	\$ 5,244,000	\$ 4,719,600	\$ 21,483,600
<u>Physicians</u>	\$ 800,000	\$ -	\$ 246,600	\$ 173,778	\$ 1,220,378
Hospital Total	\$ 15,800,000	\$ 13,900,000	\$ 12,116,600	\$ 10,781,778	\$ 52,598,378

The specific contracting initiatives outlined in this report were used to calculate the equivalent increase percentage potential during a multi-year renegotiation. These percentages were used to calculate the projected dollar impact for each contract. These projections are based on historical claims for a multi-facility hospital system and make no assumptions about case mix. Estimated net revenue impact based on historical payments as reported in claims.



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Payment (Variance) Strategy



Payment (Variance)

Strategy/Methodology

One-time or ongoing payment variance required to validate and engage in payor under/overpayment monitoring, management, & resolution.

Data Collection	Committee Development	Model Build	Payor Engagement	Ongoing Monitoring
<ul style="list-style-type: none">CDMRev/UsageClaimsFinancial StatementsContracts w/SupplementsPayerset	<ul style="list-style-type: none">Executive SponsorRevenue IntegrityManaged CareCodingDenialsAppeals	<ul style="list-style-type: none">HospitalClinics	<ul style="list-style-type: none">Meeting CadenceDashboardIssues TrackingSpecial ProjectsResolution	
Data Collection & Validation	Define Purpose	Financial Impact	Improve Collections	Institutionalize Program
Work with clients to collect, validate, & reconcile data to support work product	Develop committee charter, responsibilities, meeting cadence, monitoring for success	Build Payment Model to calculate & identify over/underpayments	Collaborate with payors to develop over/underpayment strategies	Ongoing Payment Strategy monitoring to support day-to-day activities, price strategy, & rate benchmarking

Payment Strategy – Inpatient Reporting

Example – Monthly (February 2024)

INPATIENT CLAIM ANALYSIS						
	No. of Claims	Billed Amount	Expected Insurance Payment	Total Insurance Payment	Total Variance	% (of Variance)
Paid Correctly	458	\$ 6,093,966.40	\$ 4,729,748.64	\$ 4,729,685.53	\$ 63.11	
Claim Denials	32	\$ 577,152.62	\$ 494,445.54	\$ -	\$ 494,445.54	7%
Line Item Denials	12	\$ 234,270.77	\$ 234,172.43	\$ 76,974.33	\$ 157,198.10	2%
Overpayments - Grand Total	26	\$ 73,249.90	\$ 40,618.24	\$ 82,993.53	\$ (42,375.29)	-1%
Overpayments	26	\$ 73,249.90	\$ 40,618.24	\$ 82,993.53	\$ (42,375.29)	-1%
Overpayments - Trusted Payer		\$ -	\$ -	\$ -	\$ -	
Underpayments - Grand Total	59	\$ 2,421,773.07	\$ 1,376,641.33	\$ 466,150.55	\$ 910,490.78	13%
Underpayments	59	\$ 2,421,773.07	\$ 1,376,641.33	\$ 466,150.55	\$ 910,490.78	13%
Underpayments - Trusted Payer		\$ -	\$ -	\$ -	\$ -	
Grand Total	587	\$ 9,400,412.76	\$ 6,875,626.18	\$ 5,355,803.94	\$ 1,519,822.24	
		Denial Rate	9.5%		Preliminary Collection Rate	78%
					Collection Rate (6 Month Term)	96%

Payment Strategy – Outpatient Reporting

Example – Monthly (February 2024)

OUTPATIENT CLAIM ANALYSIS

OUTPATIENT CLAIM ANALYSIS							
	No. of Claims	Billed Amount	Expected Insurance Payment	Total Insurance Payment	Total Variance	% (of Variance)	
Paid Correctly	8,038	\$ 6,157,187.06	\$ 1,403,983.83	\$ 1,403,656.39	\$ 327.44		
Claim Denials	561	\$ 625,301.56	\$ 162,022.11	\$ -	\$ 162,022.11	6%	
Line Item Denials	192	\$ 983,207.08	\$ 239,116.92	\$ 185,830.48	\$ 53,286.44	2%	
Overpayments - Grand Total	456	\$ 890,733.65	\$ 107,323.65	\$ 185,214.68	\$ (77,891.03)	-3%	
Overpayments	456	\$ 890,733.65	\$ 107,323.65	\$ 185,214.68	\$ (77,891.03)	-3%	
Overpayments - Trusted Payer		\$ -	\$ -	\$ -	\$ -		
Underpayments - Grand Total	1,320	\$ 3,064,203.69	\$ 587,005.08	\$ 324,549.81	\$ 262,455.27	11%	
Underpayments	1,320	\$ 3,064,203.69	\$ 587,005.08	\$ 324,549.81	\$ 262,455.27	11%	
Underpayments - Trusted Payer		\$ -	\$ -	\$ -	\$ -		
Grand Total	10,567	\$ 11,720,633.04	\$ 2,499,451.59	\$ 2,099,251.36	\$ 400,200.23		
		Denial Rate	8.6%		Preliminary Collection Rate	84%	
					Collection Rate (6 Month Term)	82%	

Next Steps



How should my organization prepare?



Be able to answer these key questions:

- How do the services my organization provides fit into the market?
- Is pricing justified based on the services provided? (commodity vs. specialty)
- How does my organization's payor pricing compare to peers?
- How will consumers view our organization's value? (quality for cost)
- Is our organization collecting the negotiated rates? (denials vs. payment variance)



Be prepared to navigate market pressures through development of defensible pricing strategies.



Evaluate organizational ability to enter reimbursement models requiring differentiation to earn improved revenue opportunities.

- Variations of value-based pricing design
- Combination of quality metrics, price, patient satisfaction, outcomes, & others

How Can Forvis Mazars Help?



Price Strategy

Price (Charge) development to support annual budgetary process to estimate gross & net revenue price change impacts for hospital & physician group procedures, medical supply & Rx.



Payor Specific Strategy Development

Utilizing rate benchmarks & assessment, prepare organizations to engage in more informed & proactive payor discussions



Rate Benchmarking

Assist organizations in understanding their current negotiated rate position relative to peers



Managed Care Assessment

Evaluate existing payor contracts & rate position to help clients better align their managed care portfolio



Contracting Support

Assist clients with contract negotiations & recommendations driven by rate benchmarking & assessment output



Payment (Variance) Strategy

One-time or ongoing payment variance required to validate & engage in payor under/overpayment monitoring, management, & resolution

Thank You!

