



## **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

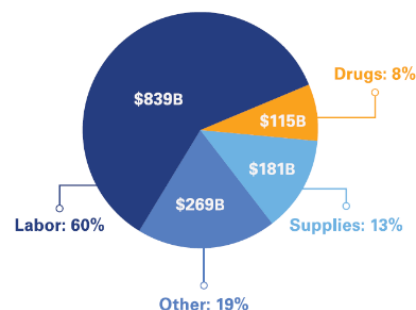
# Industry Trends



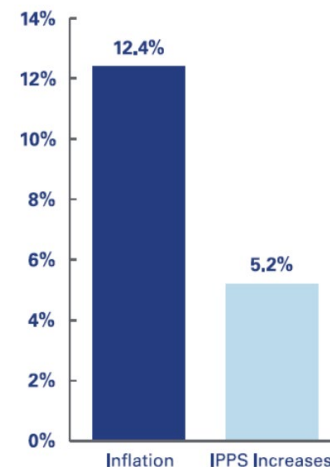
# Hospital & Health System Challenges

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

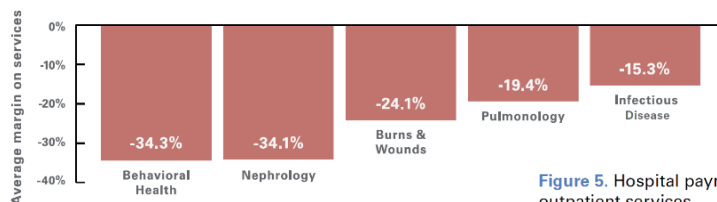
**Figure 1.** Labor constitutes largest percentage of hospital expenses.



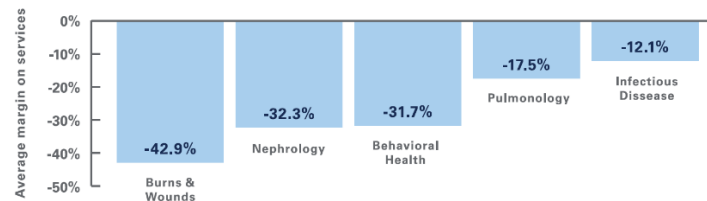
**Figure 2.** Inflation growth was more than double the growth in IPPS reimbursement, 2021 - 2023



**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



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

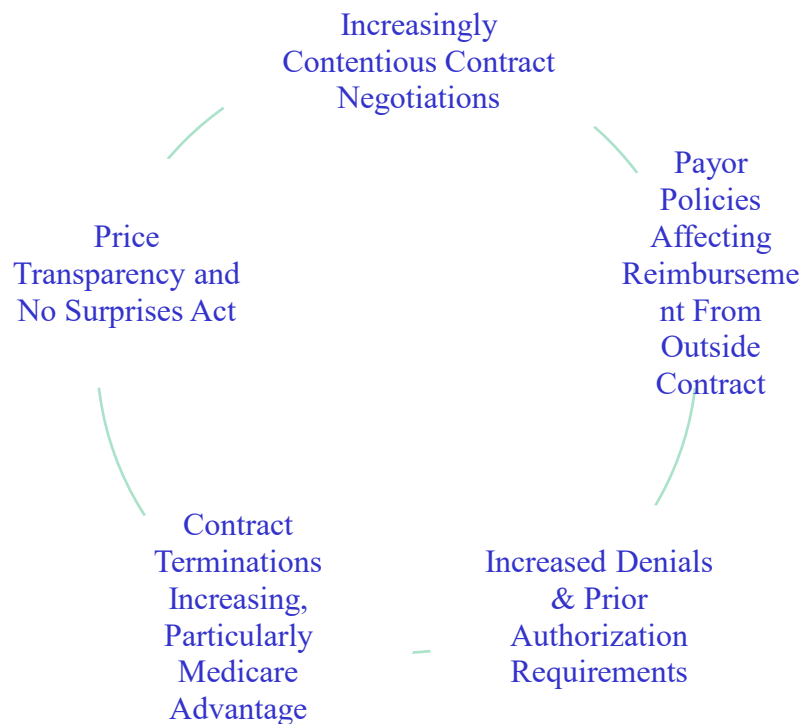


Image sources: USA Today, MedCity News, TechTarget, Becker's Hospital Review

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

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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

# Price Transparency Data

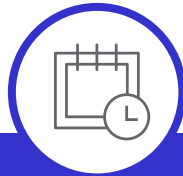


# Limitations With the Hospital Machine Readable Files

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



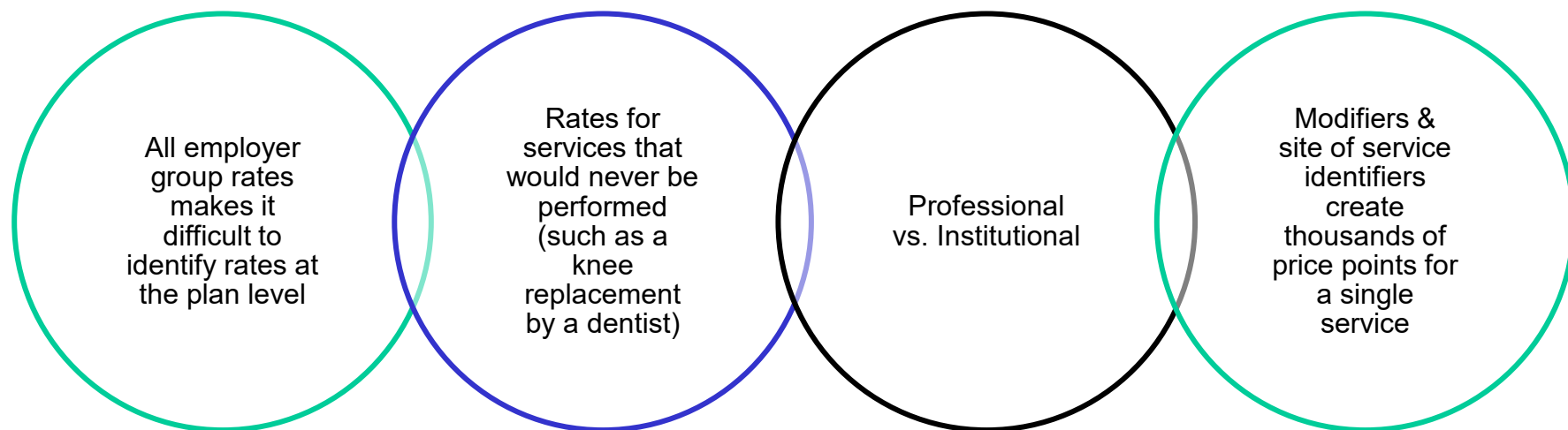
Other provider types exempted from the Rule



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

# Challenges With the Published Payor Files

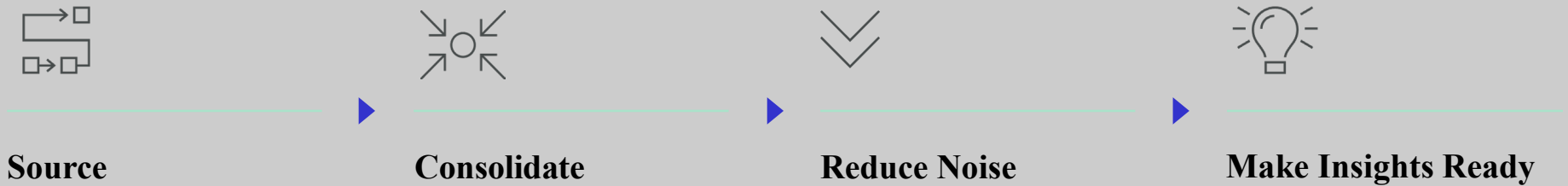
Payor data and formatting requirements are more standardized than for hospitals. However, the files include terabytes of data and payors have included millions of extraneous data points such that the files are nearly impossible for an average user to access, let alone interpret.



# 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

- CDM
- Rev/Usage
- Claims
- Financial Statements
- Contracts w/Supplements
- Payerset

### Market Position

- Peer Analysis
- Leading
- Middle
- Trailing

### Model Build

- Hospital (Procedure, Medical Supply & Pharmacy)
- Clinics

### Scenario Refinement

- Strategic Pricing
- Lesser Than
- Multiple of Payor (Public/Private)

### Rational Price

- Relational
- Levels

### Data Collection & Validation

Work with clients to collect, validate, & reconcile data to support work product

### Understand Position

How do my prices compare to peers in my geography, market, specialty?

### Financial Impact

Build Pricing Model – strategic, cost based, lesser than; calculate gross & net benefits

### Price Strategy

Develop defensible price strategy & aggregate results by payor a&depts

### New Prices

Provide uploadable file for implementation into production

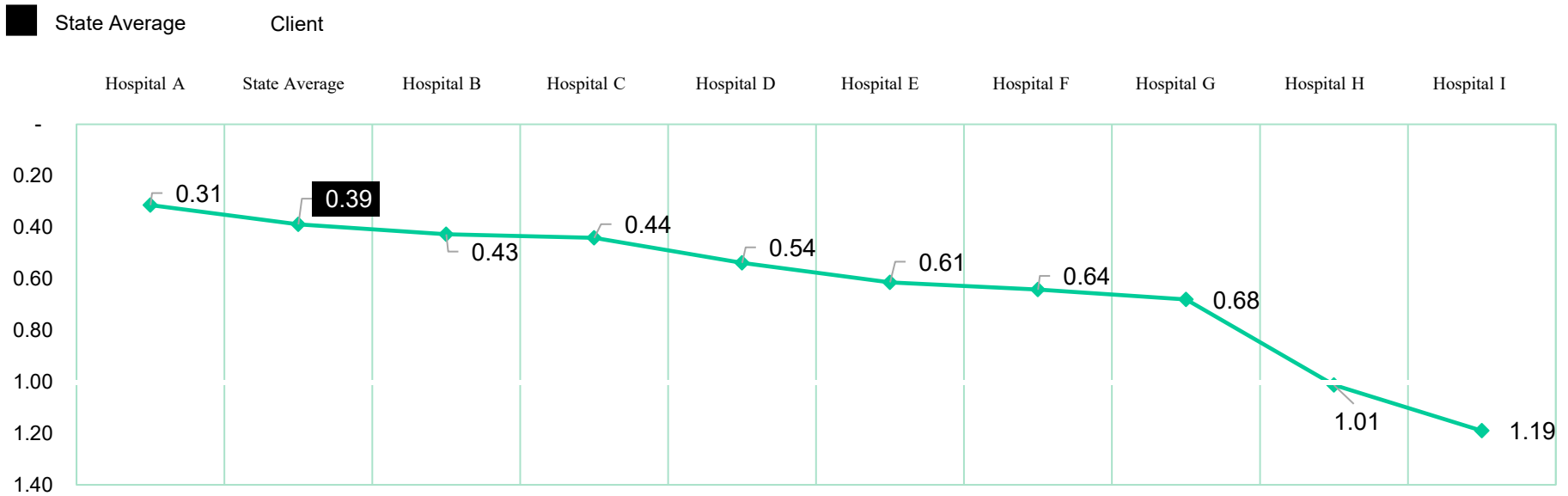


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# Overall Sample Hospital

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



# 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

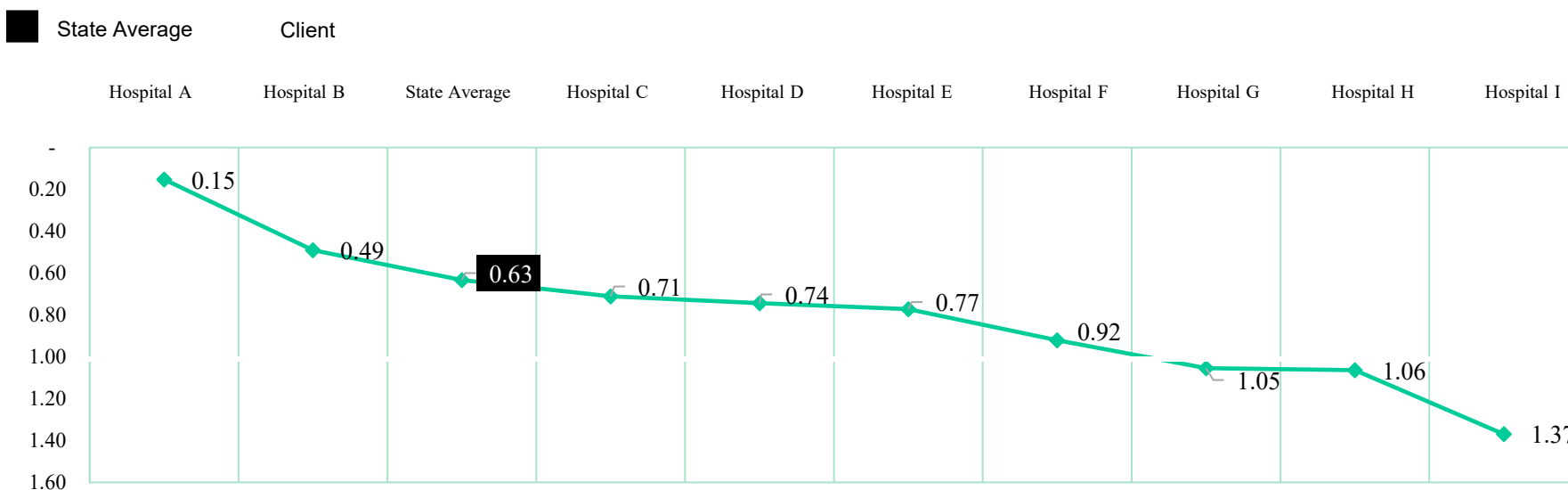
Data Source: Forvis Mazars sample client data, anonymized for confidentiality



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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

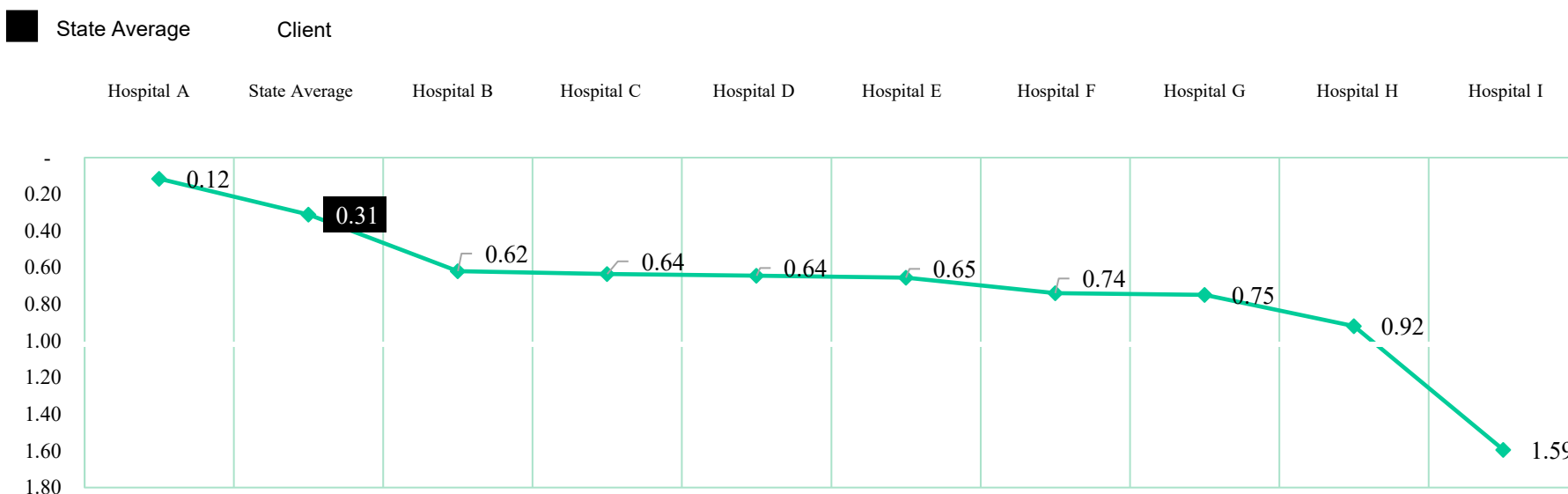
Data Source: Forvis Mazars sample client data, anonymized for confidentiality



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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

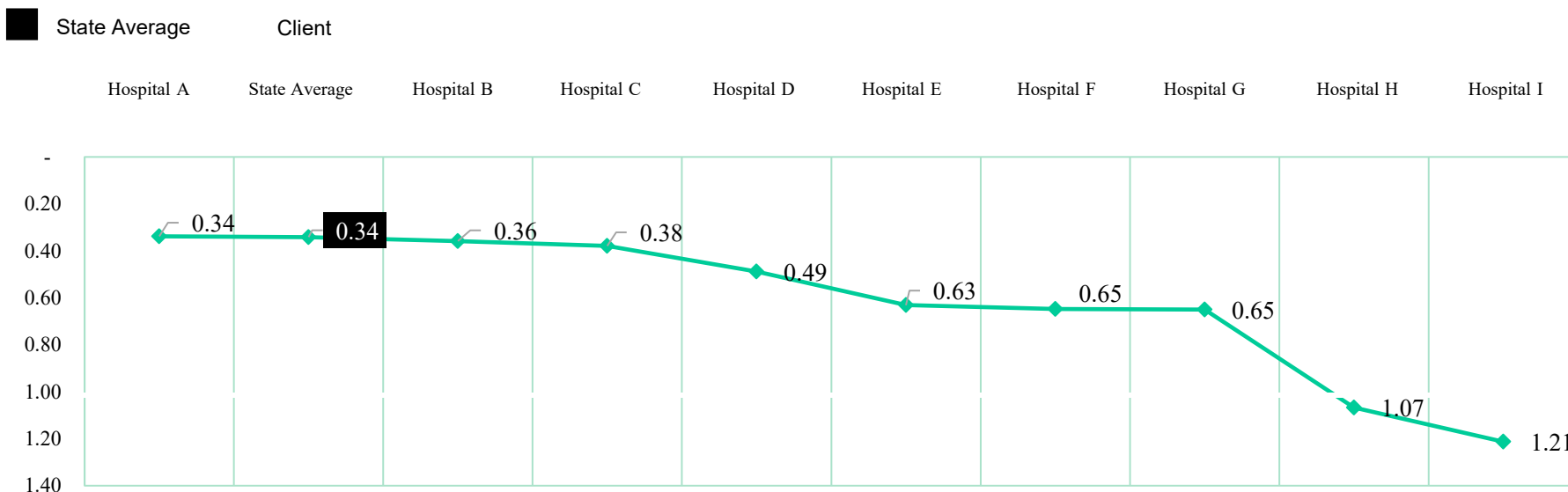
Data Source: Forvis Mazars sample client data, anonymized for confidentiality



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# Department Specific

## Surgery (Represents Supplies & Implants)

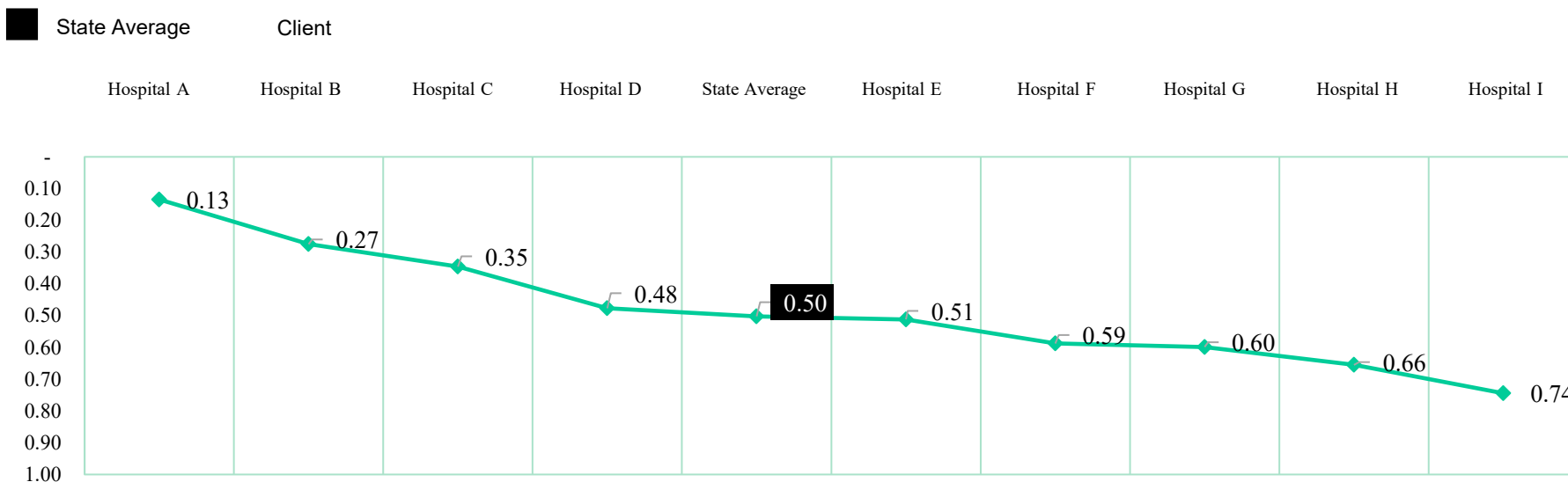


- Client's gross charges are X amount of the competitor's gross charges
- Client department Surgery is priced below 8 competitor facilities (including the state average) and priced above 2 competitor facilities

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

# 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



# 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)

# 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



# 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 \$ <b>Gain</b> (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 Adjusted Net \$ Pickup

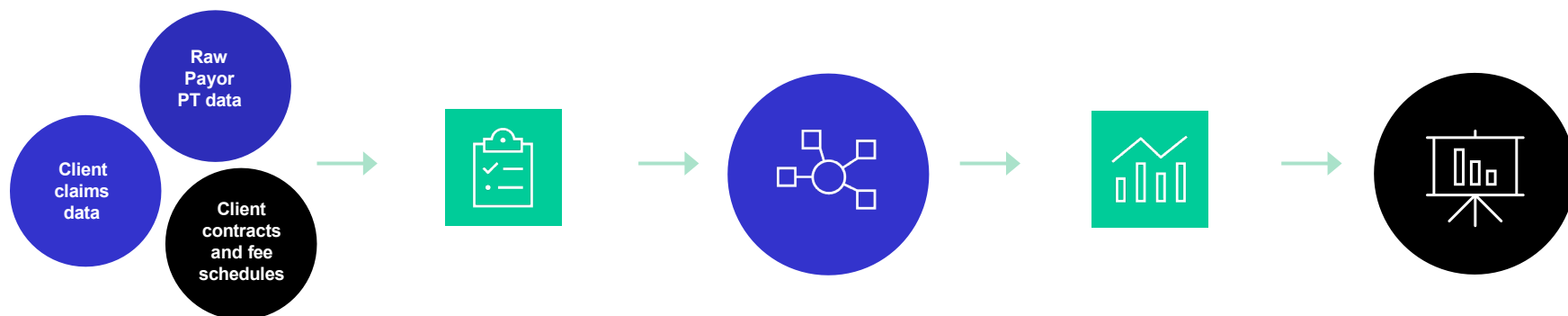
Take-Back Amount Calculation for all payors

# 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

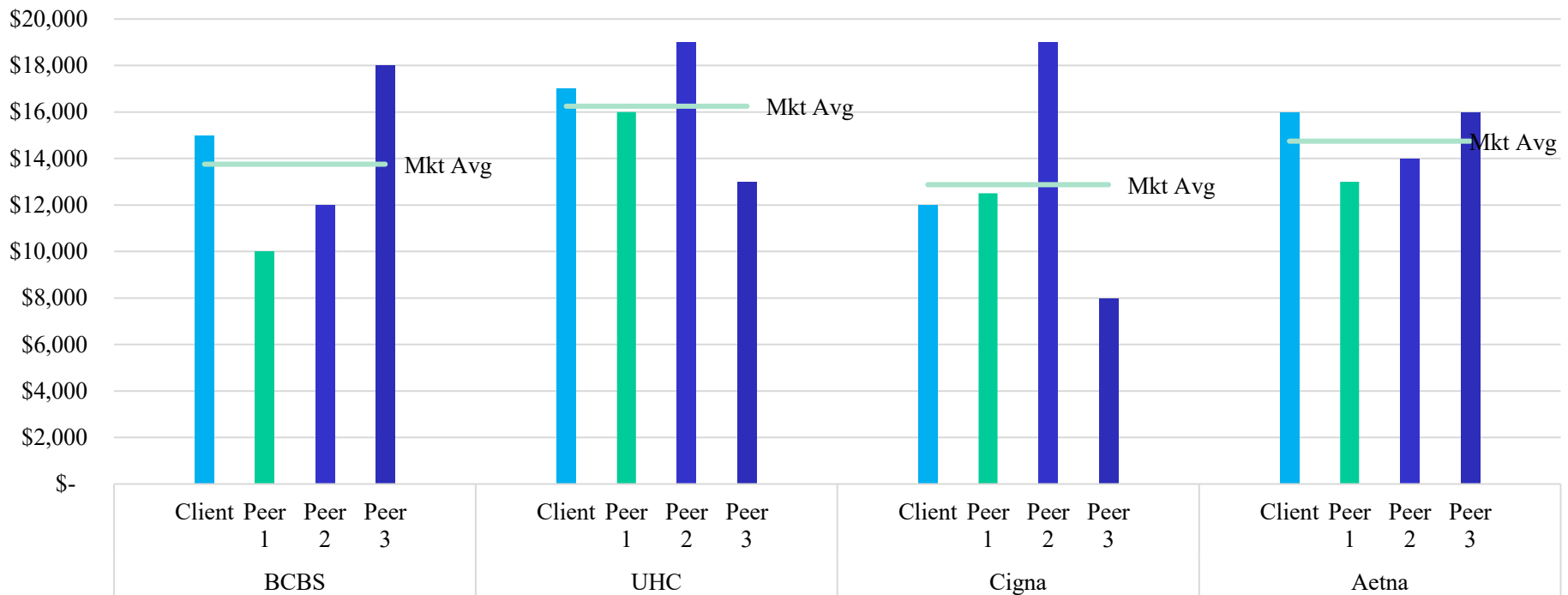
# Negotiated Reimbursement by Payor

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

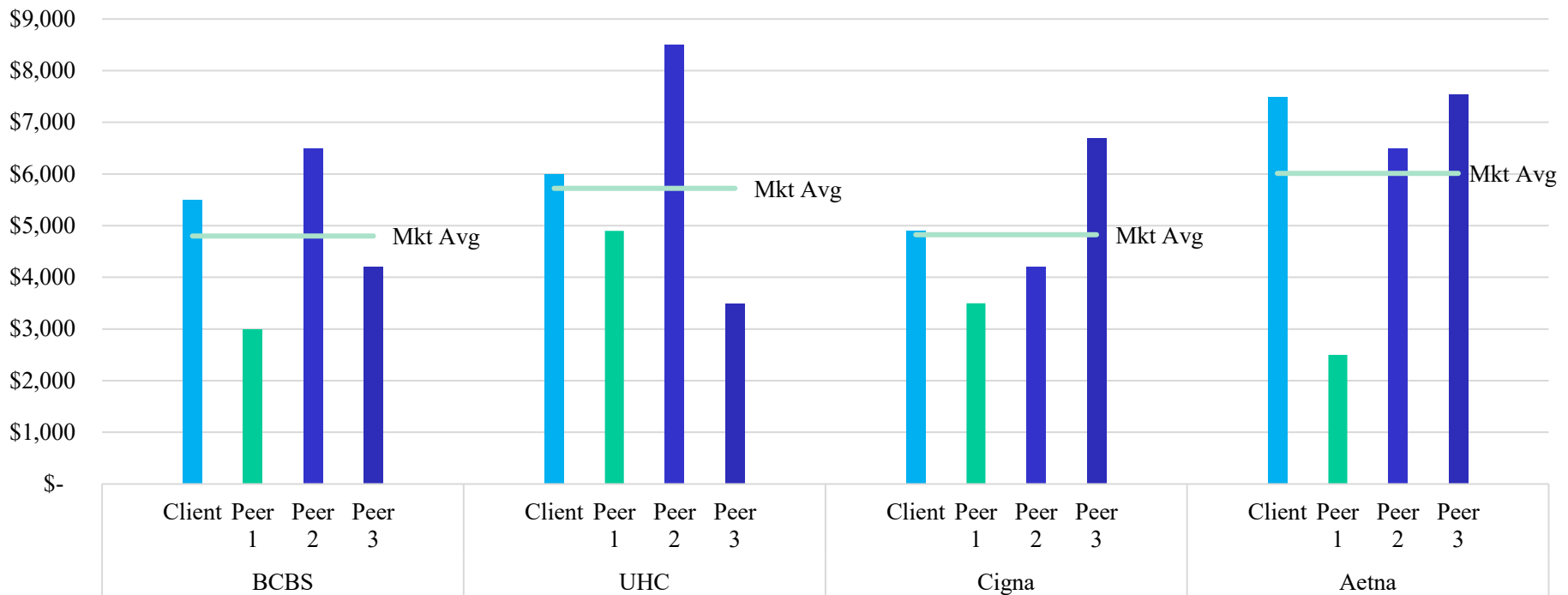
The graph below shows a client's payor-specific rates relative to peers for inpatient services, shown here as weighted average case rates. The market average by payor has also been graphed.



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

# 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

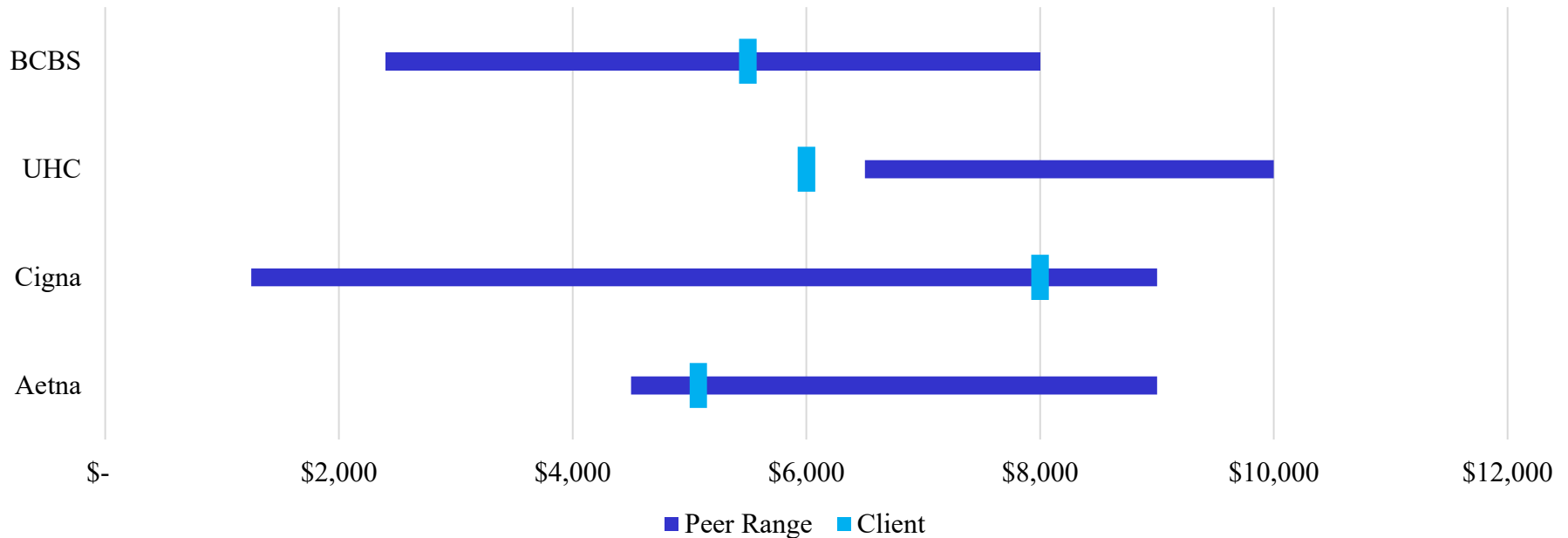


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# HOPD Surgery

## 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.

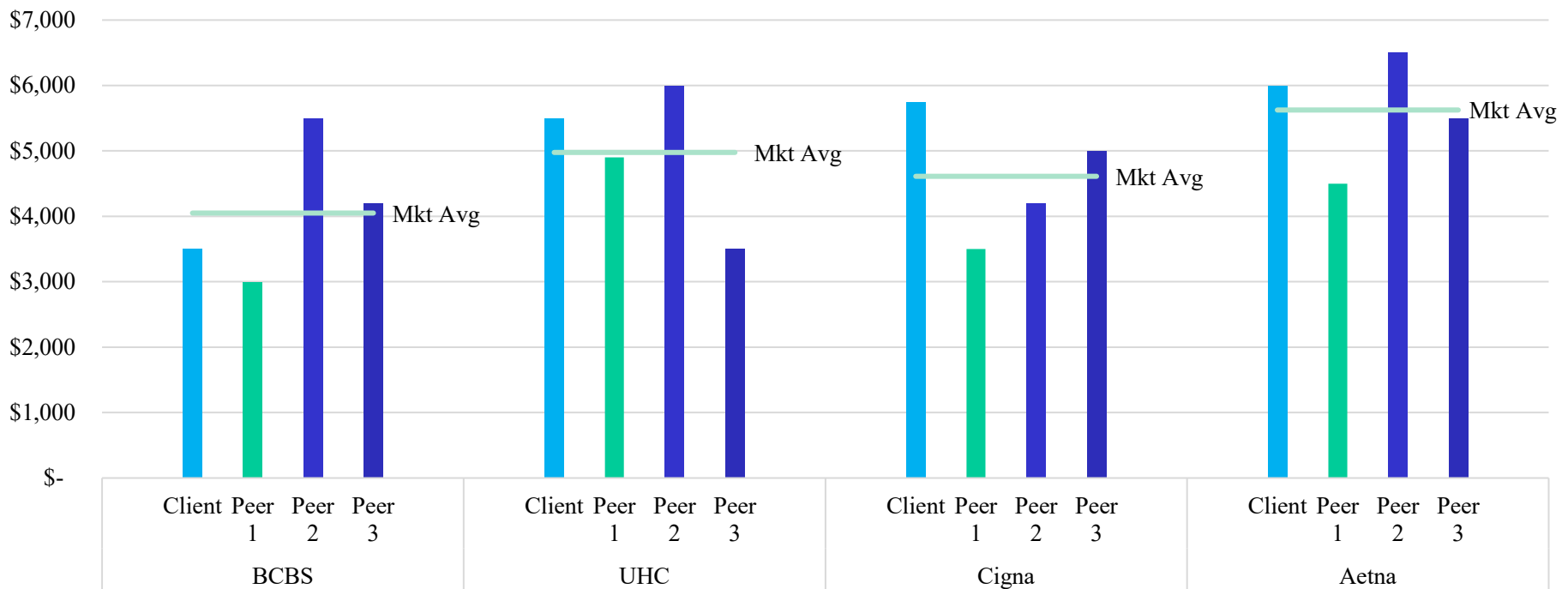


Data Source: Forvis Mazars sample client data, anonymized for confidentiality



# Emergency Department

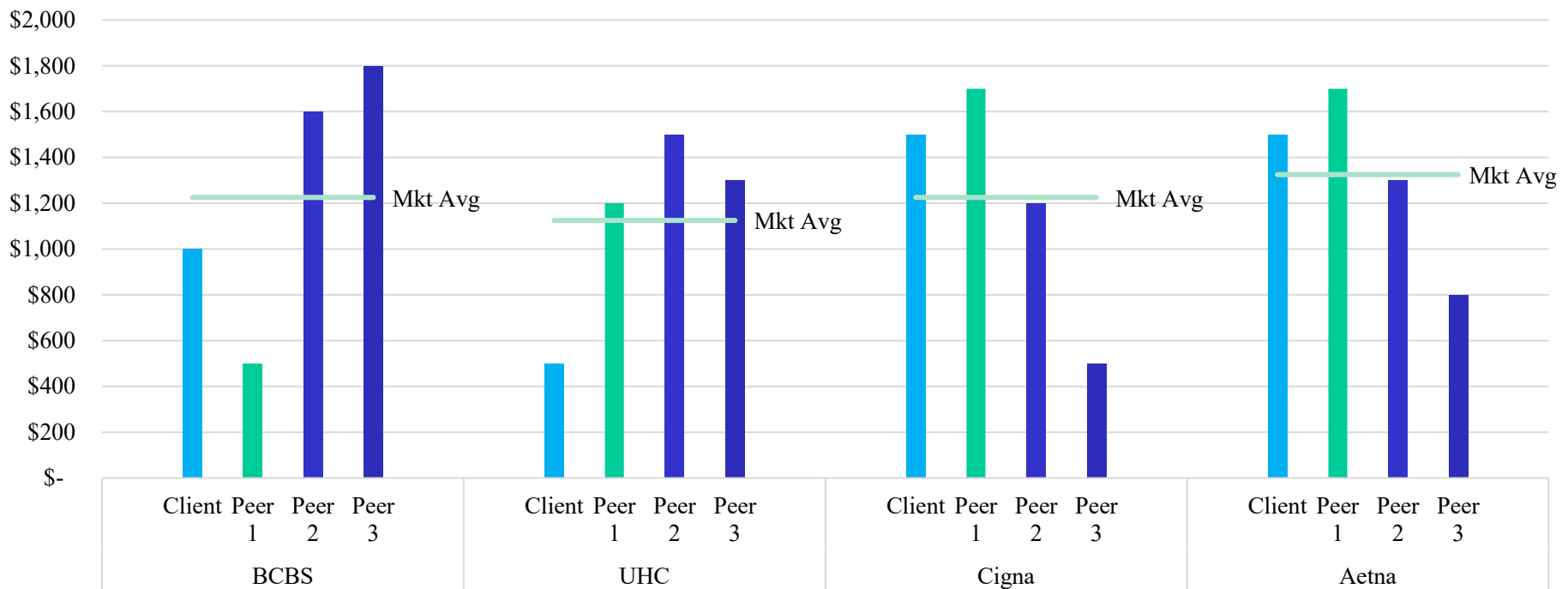
The graph below shows a client's payor-specific rates relative to peers for Emergency Department services, shown here as weighted average case rates. The market average by payor has also been graphed.



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.

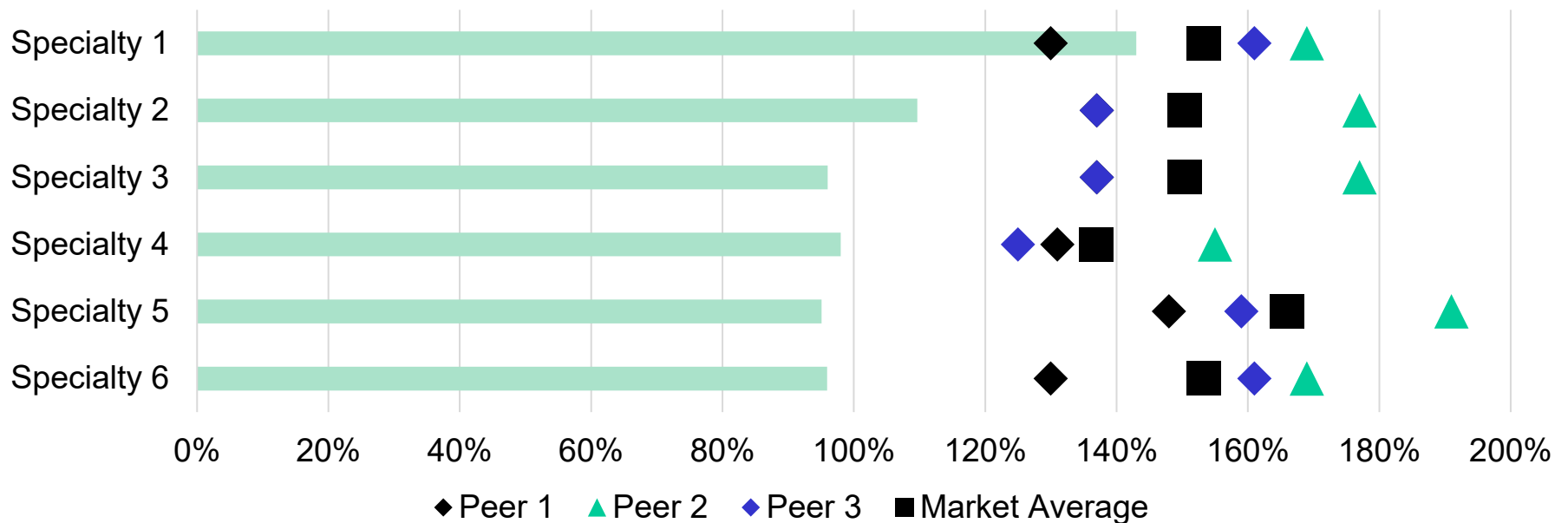


Data Source: Forvis Mazars sample client data, anonymized for confidentiality

# Physician Benchmarking

BCBS

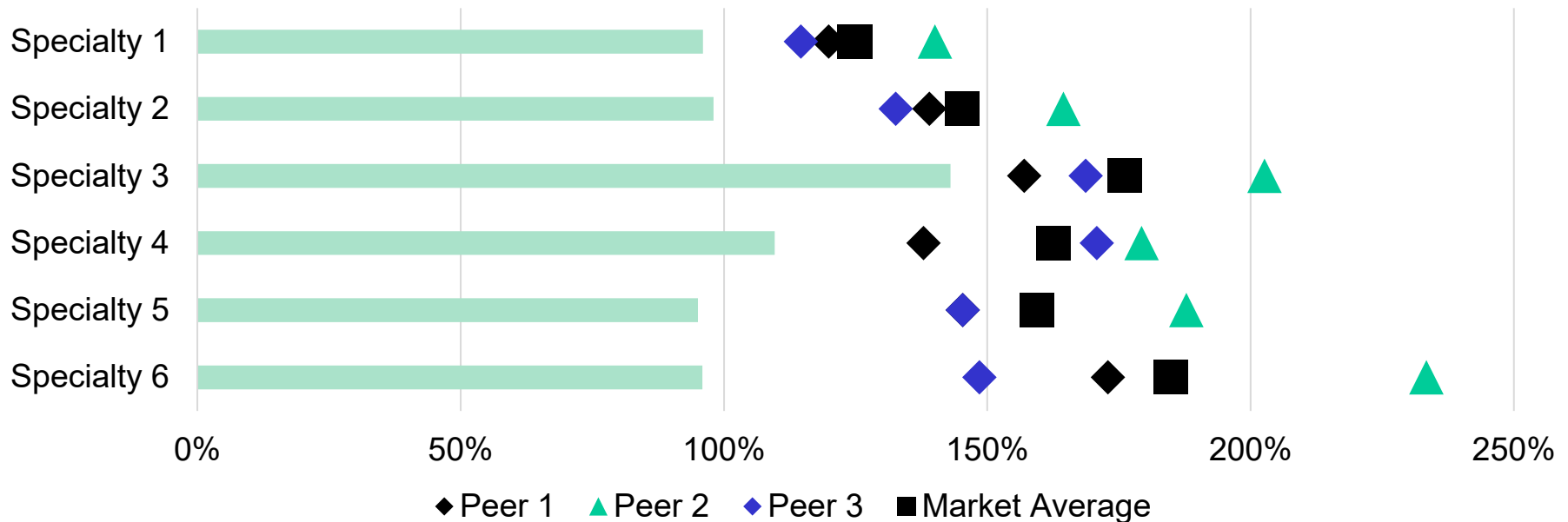
The graph below displays a client's pricing performance relative to peer benchmark and market benchmarks by specialty as a percentage of CMS, e.g., primary care, orthopedics, etc.



# Physician Benchmarking

UHC

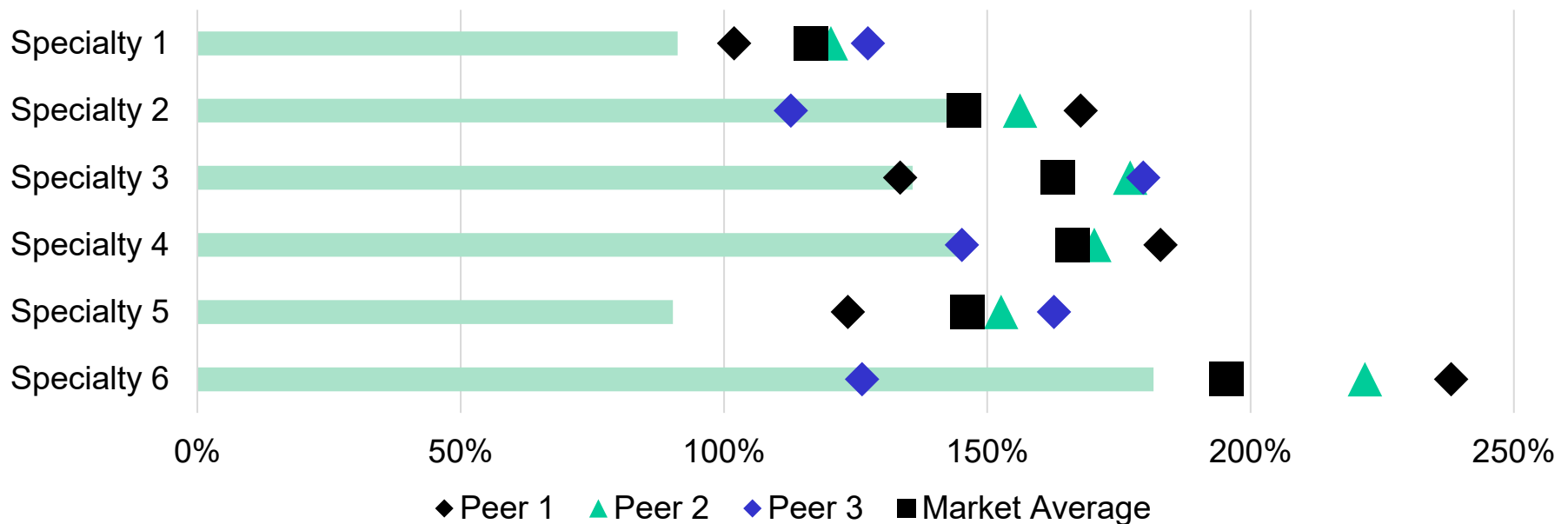
The graph below displays a client's pricing performance relative to peer benchmark and market benchmarks by specialty as a percentage of CMS, e.g., primary care, orthopedics, etc.



# Physician Benchmarking

Cigna

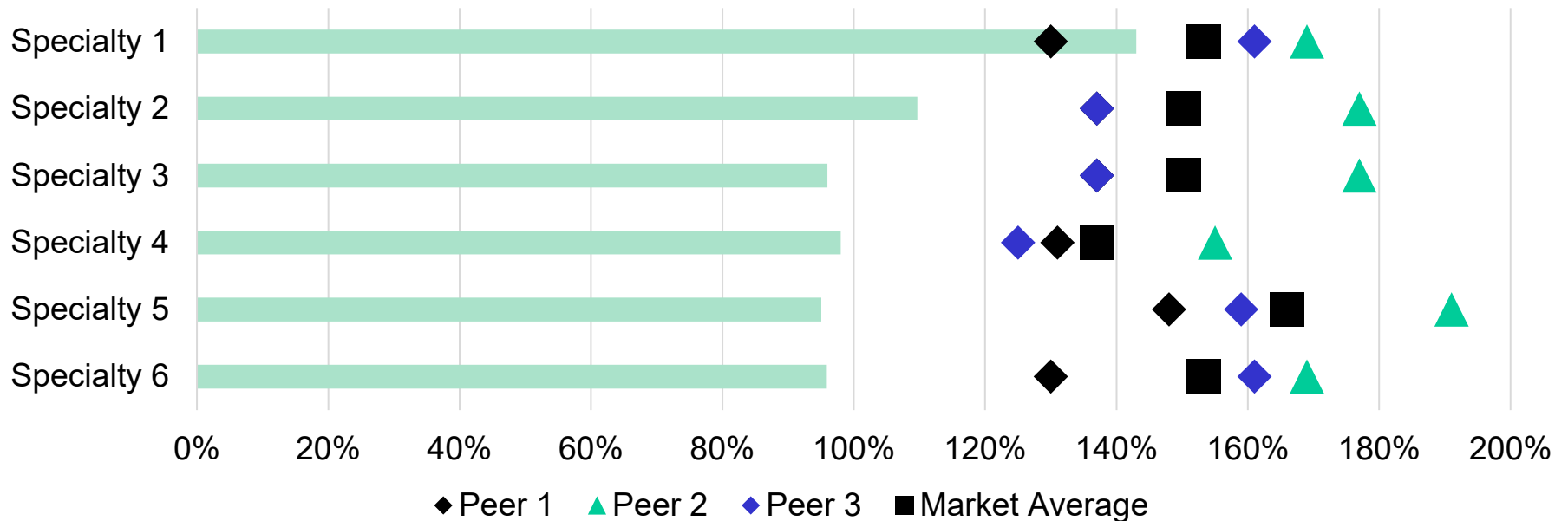
The graph below displays a client's pricing performance relative to peer benchmark and market benchmarks by specialty as a percentage of CMS, e.g., primary care, orthopedics, etc.



# 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.



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





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



# 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

- CDM
- Rev/Usage
- Claims
- Financial Statements
- Contracts w/Supplements
- Payerset

### Committee Development

- Executive Sponsor
- Revenue Integrity
- Managed Care
- Coding
- Denials
- Appeals

### Model Build

- Hospital
- Clinics

### Payor Engagement

- Meeting Cadence
- Dashboard
- Issues Tracking
- Special Projects
- Resolution

### Ongoing Monitoring

### Data Collection & Validation

Work with clients to collect, validate, & reconcile data to support work product

### Define Purpose

Develop committee charter, responsibilities, meeting cadence, monitoring for success

### Financial Impact

Build Payment Model to calculate & identify over/underpayments

### Improve Collections

Collaborate with payors to develop over/underpayment strategies

### Institutionalize Program

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

INPATIENT CLAIM ANALYSIS						
	No. of Claims	Billed Amount	Expected Insurance Payment	Total Insurance Payment	Total Variance	% (of Variance)
<b>Paid Correctly</b>	458	\$ 6,093,966.40	\$ 4,729,748.64	\$ 4,729,685.53	\$ 63.11	
<b>Claim Denials</b>	32	\$ 577,152.62	\$ 494,445.54	\$ -	\$ 494,445.54	7%
<b>Line Item Denials</b>	12	\$ 234,270.77	\$ 234,172.43	\$ 76,974.33	\$ 157,198.10	2%
<b>Overpayments - Grand Total</b>	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		\$ -	\$ -	\$ -	\$ -	
<b>Underpayments - Grand Total</b>	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		\$ -	\$ -	\$ -	\$ -	
<b>Grand Total</b>	587	\$ 9,400,412.76	\$ 6,875,626.18	\$ 5,355,803.94	\$ 1,519,822.24	
		<b>Denial Rate</b>	9.5%	<b>Preliminary Collection Rate</b>		78%
				<b>Collection Rate (6 Month Term)</b>		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)
<b>Paid Correctly</b>	8,038	\$ 6,157,187.06	\$ 1,403,983.83	\$ 1,403,656.39	\$ 327.44	
<b>Claim Denials</b>	561	\$ 625,301.56	\$ 162,022.11	\$ -	\$ 162,022.11	6%
<b>Line Item Denials</b>	192	\$ 983,207.08	\$ 239,116.92	\$ 185,830.48	\$ 53,286.44	2%
<b>Overpayments - Grand Total</b>	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		\$ -	\$ -	\$ -	\$ -	
<b>Underpayments - Grand Total</b>	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		\$ -	\$ -	\$ -	\$ -	
<b>Grand Total</b>	10,567	\$ 11,720,633.04	\$ 2,499,451.59	\$ 2,099,251.36	\$ 400,200.23	
		<b>Denial Rate</b>	8.6%	<b>Preliminary Collection Rate</b>		84%
				<b>Collection Rate (6 Month Term)</b>		82%



northern new england chapter

# 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.



## 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



## Payor Specific Strategy Development

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



## 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!**

