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Payer Contracting: It's Complicated

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One of the biggest risks for healthcare CFOs right now is underestimating the extent to which payer contracting has become intertwined with every aspect of organizational strategy.

Life was simpler in the old days. If a hospital CFO could negotiate substantial increases from private payers, and Medicare increases were reasonable, life was good. Sure, there was the challenge of managing operating costs. But it was someone else's job to worry about market share, quality, physician alignment, and countering competitors.

Now, contracting is a multifaceted strategic endeavor. Each contracting decision is complex, and success depends on multiple stakeholders. Even Medicare, the low-paying but dependable bastion of simple contracting, has pushed complicated questions on hospitals: Should we do a bundled payment pilot, or an ACO deal? How can we avoid readmission and quality penalties?

Whether you are talking about risk arrangements, shared savings, bundled payments, pay for performance, or tiered networks, there are several questions to consider beyond the direct contractual results.

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Can we strengthen our relationships with physicians through this contract? A contract that gives physicians greater financial opportunity with your hospital or health system could help align physician interests and better secure physician loyalty. Many new payment arrangements open the door for greater sharing of incentives with physicians (all subject to regulatory requirements, of course). Healthcare organizations that don't create these opportunities for affiliated physicians may lose out to those that do.

Can we reduce operating costs? With Medicare increases below 1 percent, and pressure from private payers, reducing operating costs is an imperative for almost every hospital. Some payer arrangements, like bundled payments, can engage physicians in smoothing clinical workflow and reducing supply chain costs. Although the contracts may apply to a fraction of total patients, the benefits of cost reduction may accrue across all patients as physicians adjust their approaches.

Can we retain or grow market share? In payment models designed to reduce utilization, shared savings and other incentives rarely make up for lost hospital revenue. So why consider these options? Assume *someone* is going to squeeze down unnecessary utilization. It could be a competing hospital's ACO or a physician network's ACO, or primary care physicians with patient-centered medical homes.

To offset volume lost due to reduced utilization, look to better coordination of care. It can reduce leakage for follow-on care, keeping more patients at your hospital.

Healthcare organizations need to apply a strong analytic structure that compares these factors across all different types of payment models. A colleague and I discuss one such structure in an article published in the April 2013 issue of *hfm*, "The Transition to Emerging Revenue Models."

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