10 Points for Negotiating Hospital Contracts

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Executive Summary

The Challenge
The Medicare world of “more is more” has been replaced with the managed care world of “less is more” with a contracted expectation of even better financial and clinical outcomes under managed care.

Hospitals, ACOs, and managed care companies are sizing up their post-acute networks and inking contracts with partners who bring attractive data-driven outcomes to the table. We’re constantly under pressure to perform and meet contractual obligations or be unseated by others having better outcomes for return to acute, average length of stay, mortality rates, delivering a continuum, and better coordinated care between partners.

The Takeaway
Contracts have been our M.O. in California for several years, and they are sweeping markets across the country as ACOs, bundled payment pilots, and capitated Medicaid programs take hold. In this paper, we’ll share 10 points we’ve learned about negotiating contracts. While we refer to hospitals as the audience with whom we negotiate, we apply the same principles with physician groups, ACOs, or managed care. You’ll get:

- Ways to justify share without losing your shirt
- The tough questions they’ll ask, to help you prepare for meetings
- A glimpse into what a day/week/month holds in store for you across multiple layers of the organization
- Strategies for building profitable models of care, even in a dynamic healthcare environment

The Bottom Line
Adverse selection is here to stay. While you’ll be welcomed as a partner at the negotiating table, be sure to protect your business interests before you ink a deal. Your referrals, revenues, expense levels, and reputation depend on it.
Market Overview

In San Diego County, there are 360,000 people over the age of 65. 76,000 of them are dually eligible for Medicare and MediCal. With 85 nursing homes, the environment is intensely competitive.

Meet Our Tough Customers

Managed care is not an experiment but a way of life. Three, large organizations with a lot of negotiating power dominate the landscape. We have three contracts with these top referral sources who deliver the majority of our volume. We’re in a very dynamic environment.

We learned that contracts don’t guarantee patients, but we don’t get patient volume without contracts. And once we win them, managed care providers want constant confirmation that we’re committed.

Developing Relationships

We keep hospitals engaged with convenience, economies of scale, quality outcomes, and contained costs. We also need to reflect the value system of our customers. Relationships unfold as follows:

- **Initial engagement.** We chose to be first with bold opening moves. We knew if we didn’t get it in early with a big message, we’d be bypassed by others who would.

- **Prove value.** We know our metrics relative to our competition. At first they viewed us as a commodity; which drove urgency for us to prove value early in our relationship. If we had an edge at all, it was knowing that if they failed us, they would fail themselves. But if we failed them, we’d be out of business…literally!

- **Improving outcomes.** After the deal was signed, the negotiating was far from over. Our performance is reviewed daily in one contract in particular but monthly at a minimum. Managed care providers expect us to bring data-driven, continuous improvements as well as innovations to the table.

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1 U.S. Census Bureau
Point #1: Offer Value

When we started our journey three years ago, we were a pure-play skilled company. Today, we are a ‘what do you need’ resource that creates a lot of value for a healthcare network – value that would be expensive and time-consuming for the networks to create on their own. We speak among our management team that we’re now more of a logistics company that happens to be in the healthcare business.

To get to where we are, we’ve done a lot of experimenting. Some have been famously successful; some have been total duds. We encourage people to stretch and make mistakes. It’s how we built a more robust and elastic product.

We now have the infrastructure of a value creator and are positioned to take on increasing levels of financial risk. Innovations include:

- **Central intake.** We learned from logistics companies how to leverage resources and gain efficiencies with centralized intake. With a single phone call, a core group of people offers a full portfolio of services along the continuum of care. Whatever service they need, we figure out how to provide it. Sometimes it means committing resources to get the customer what they need, even though there is no upside in the transaction for us… a take away from Nordstrom’s famous customer service.

- **Services.** We offer choice: home healthcare, in-home remodeling, hospice, skilled care, assisted living, independent living, transportation, meal delivery, and more. We’re creating an environment of convenience for customers with the goal of becoming their “trusted advisor.”

- **Technology Deployment.** There has been a huge investment in upgrading technology, and, in some cases, having to create new technology to meet our needs. (More on this later.)
• **MDs on the ground.** A couple of years ago, we had a very typical medical director. The typical medical director is being supplanted by teams of medical professionals like SNF-ists, hospitalists, nurse practitioners, physician assistants, and other highly specialized staff. And they have real and dynamic roles, not just contracts intended to drive Medicare patients to your door step.

• **Transition coaches.** Like an “eldest daughter,” these unique individuals are proponents for the patient—not for an episode, but for a lifetime. They match services to needs. Their job is to advocate, not drive revenue. It is the right thing to do for the customer and it creates a very healthy conversation within the various teams responsible for efficient service delivery.

• **Five levels of touches.** There was a book that coined a phrase by Jan Carlzon, formerly of Scandinavian Airlines, called “Moments of Truth.” If you get a chance, it is a very quick but meaningful read. These are our “Moments of Truth”. They work in concert as we coordinate care across the following:
  
  o Acute providers
  o In our facilities
  o At care transition times (healthcare, episodic)
  o As advisors over the long term (lifestyle, social)
  o At our call center

When they do their job well, this team is not a cost center. It is a revenue driver.

We have found these concepts to be very well received. However, we have found the biggest obstacle to be decades of doing business a certain way and trying to turn the forces of inertia toward a new customer service paradigm. Be prepared for a multi-year initiative in any organization regardless of your size.
Point #2: What They Have on You

So you ask for a meeting and get one, or have been called into one. What will they have on you before you arrive? What is their frame of reference?

Avoid This

Here’s a real story from a woman we met while attending a conference in Northern California, who explained how her skilled facility was selected by an ACO. She had not approached the ACO but instead was invited to a meeting along with four other skilled facilities. When she asked why her facility plus the others had been invited, they were told it was due to quality metrics for the following: LOS, readmissions, and 5-Star.

Here’s the interesting part: she’s not even sure how they got her data. The ACO performed due diligence on skilled candidates and narrowed their choices long before anyone knew what they were doing.

Know Your Data

During the last 12 months, the market has grown much and is more analytically driven. Today, we don’t underestimate managed care’s understanding of our metrics. We learned very quickly that if we don’t know our metrics with great granularity, they will eat our lunch.

The bottom line: be prepared to negotiate with educated customers who may already have a thick file on you. Be ready to defend your strengths…and play offense with your data story (next point).

Additionally, there are only a few metrics being talked about. At this point, we have a plethora of real-time data that goes way beyond length of stay, return to hospital, etc. Our metrics encompass our abilities and elasticity of performance in other systems including purchasing, logistics, coordination of care, technology, and financial systems—to name a few.

In a managed care world success is defined in the moment, not at the end of the month.
Point #3: The Power of Data

The majority of our volume is governed by a handful contracts. In order to stay alive in contracts, we learned we must have the information - across the continuum - clinical and financial - if we are to take on risk or share risk for a full episode of care. Top outcomes measured are:

- 5-Star data from CMS
- Return-to-hospital rates of 10% or lower
- Mortality rates
- Length of stay
- Appeals
- Our ability to say yes to 95% of admissions in 15 minutes or less

If we fall outside of ranges for certain metrics, there are financial penalties including a contract becoming null and void. They'll go elsewhere. We must demonstrate and measure performance and outcomes.

Direct the Data, Drive the Discussion

We don’t want to get caught in a trap where the actuaries of our partners are telling us how we’re performing. We want to be in the driver’s seat. As a result, we created portals and dashboards for the hospital system and their physicians to share and jointly manage these metrics and other data points. We provide them with far more granularity than they can get using public sources on us. That way, we stay in control of a data-driven conversation. With our available analytics, we can even go one step further and suggest ways to drive their own numbers toward better outcomes by using us more rather than less. We propose solutions without waiting for the hospital to come to us.

Families Value Data Too

We also use our same data-driven outcomes story, (lower return-to-hospital rates, lower length of stay, high quality care, etc.) when speaking with families. It helps them weigh options when unfamiliar, difficult decisions must be made.
Point #4: Price vs. Volume

One of the biggest challenges we had to face was revenue compression. Some compression was due to rate but mostly it was due to a reduction in the length of stay. Most expenses are in labor ...increasing it was not an option. We’re rethinking and optimizing the skill levels of our staff.

Patient Mix

We knew to survive revenue compression we had to position ourselves for volume. Our patient mix went from:

<table>
<thead>
<tr>
<th>Year</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>90% Custodial</td>
</tr>
<tr>
<td>2013</td>
<td>65% Skilled</td>
</tr>
<tr>
<td>2014</td>
<td>75% Skilled</td>
</tr>
</tbody>
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Revenue

Whereas we can get an average of $18K per Medicare patient for a fee-for-service patient, we get as little as $6K (or less) for a managed care patient. Knowing many organizations would find it tough to survive a 50-70% cut in overall revenues, we knew we had to make it up in volume. Volume is unpredictable. Technology-driven efficiencies, service logistics, clinical workflows, “on the fly” team-oriented problem solving and an advocacy approach to the continuum have been strategic to our success.


**Length of Stay**

When we started, our average length of stay for Medicare Part A was 25-35 days per patient. At first, managed care asked for a 14-day average day length of stay; then it moved to 10-12 days in contracts. Now there is some conversation about that number dropping to single digits.

In all cases, we can demonstrate equal or better clinical outcomes by every measure because of an integrated team approach between the various partners including the patient. Revenue aside, it is a pretty cool thing to say we are a leader in getting patients home sooner and keeping them home longer. It is a real competitive advantage.

**How we reduced ALOS**

Disease management was key to LOS compression. We implemented COMS Daylight IQ and partnered with AHCA, CAHF and the University of Nebraska for advanced training in gerontology for our nursing staff.

**Admissions**

Put in the contract who you can and cannot take. Make the rate paid a sliding scale if you can, based on volume or beds filled. Otherwise, you are going to end up with empty beds, less revenue, and no incentives to drive patients your way other than outcomes. While that should be enough, it is often not.

Our partners expect us to take 95% of admissions in 15 minutes or less. At the moment of truth, our team can't say we take this patient and not that patient. Prevent headaches for you and your partners by defining acceptable admissions processes and parameters upfront. This is another area to demonstrate creativity, convenience and efficiency. It is also the right thing to do in empowering your staff by providing clear decision making guidelines.

“At first, managed care asked for a 14-day average day length of stay; then it moved to 10-12 days in contracts. Now there is some conversation about that number dropping to single digits.”
Point #5: Get Costs in Order

We used to drive revenue by providing more services. In a capitated world of episodic payments, we will be a cost center and survival will increasingly be all about providing strategic services.

New Levels of Transparency

As our conversations ensued with hospitals, we wanted to know to what extent they have control over their costs, since as a team, we’d be dependent on each other to achieve bonus payments. Transparency is key across the network from a cost perspective; we get it in writing and hold them accountable. Don’t assume there is mutual agreement about definitions for measurements or you are going to be surprised and disappointed.

We learned we must really know our cost structures in the moment. While we’re not there yet, we will need to know costs by:

- Patient/family member (some family members eat up a lot of real resources like staff time)
- Staff person/shift/team
- Diagnosis
- Episode
- Physician/managed care team
- Ancillary products and services – items that, two years ago, weren’t on our radar at all.

…And ways we haven’t even thought of yet.

Knowing our costs will help define what levers we can pull to drive value in contract fulfillment when risk is shared.
Point #6: Technology Partners

Core to our model is the way we leverage technology; as a result, we take a very strategic approach to selecting the right partners. Our company culture is service driven, and we look for committed partners who share this vision. We’re not big enough to have a lot of technical expertise in house, and in the same way we challenge our managed care partners, we count on technology partners to act as an extended team, bring innovations to the table, and help us work through challenges.

Our model depends on teams empowered to drive and measure quality with the data they need at the moment of truth. The systems on which we rely include:

- **Electronic medical records.** So much more than just documentation, they are increasingly core to assessments, care planning, and care transitions across the continuum. American HealthTech is our partner, helping us drive our unified vision for interoperable health records.

- **Outcomes reporting.** With American HealthTech, we have instant access to readmission rates, length of stay, and other reports that allow us to drive measurable results. Managed care partners are data-driven and expect constant updates on our performance. We can also use Outcomes Reporting to drive continuous improvement for quality programs like QAPI.

- **Disease management.** We implemented the COMS Daylight IQ program and have seen great results with nurses and physicians. The resulting dialogue is more interactive, and allows us to predict vs. react to what the outcomes will be. COMS is contributing to reduced length of stay and return-to-hospital rates in very measurable ways.

Exchanges are an area of opportunity and we feel that the platform we’re building positions us well for the future.
“Just because the hospital CEO signs a contract with our organization, we don’t always see discharge planners follow suit.”

Point #7: Vertical Communication

Vertical communications have been a challenge in every deal we’ve inked. Just because the hospital CEO signs a contract with our organization, we don’t always see the discharge planners follow suit.

While we’ve accomplished these:

- We are half the average for return-to-hospital rates or better compared to county, state, national levels. Our return-to-hospital rate is 11% with a very high acuity population
- Patients go home in half the time, typically in 10 to 14 days
- We are 75% to 90% better than peers in mortality rates
- We are saying yes to 95% of admissions within 15 minutes which demonstrates we are not cherry picking

In spite of these results, discharge planners still may not be on board. A culture clash is underway; discharge planners aren’t understanding why senior leadership is involved in the referral process.

We’ve had to bridge their internal communication gap by having our clinical liaisons meet daily with hospital staff to facilitate referrals.

One area to be aware of: review state and federal regulations regarding patient choice; and be advised how your hospitals are managing it.
Point #8: Optimize Physicians

While there is a lot of talk about healthcare reform being about patient-centered care, it often feels more like physician-centric care. Patients follow their physicians, and as a result, the healthcare networks increasingly want their physicians and brands in our building.

Balancing Act

We’ve seen this issue come up in several negotiations with hospitals and chances are, if you haven’t run into it yet, you will in the future. Here’s our challenge:

- **Cooperation.** Hospitals want to put their doctors in our buildings and that’s contributing to reducing readmissions by 50%. Some have asked for office space in the facility and we welcome the opportunity to have as much onsite physician engagement as possible. We like the results we’re seeing.

- **Cooperation…and control.** Some hospitals have asked us to private-label our buildings, creating conflict with our other contract partners. While others are embracing a private-labeling strategy, for us, retaining autonomy is a top priority. It impacts your ability to deliver a diverse revenue stream which, in turn, will impact the value of your community/company. Our lever in negotiations has and will continue to be our range of services and data-driven outcomes.

Congress of Resources

Yet another area we had to re-think was the role of a traditional medical director. A year ago, we could have not have had this conversation, but now there is shared urgency to keep patients in our buildings. We’re innovating a “congress of resources” with managed care partners, competing specialists, SNF-ists, hospitalists and more – to promote dialogue amongst the constituencies. Objectives include:

- Improved coordination of care.
- Policy and program development cross the system.
- At the community level, it’s for training, regulatory compliance, and managing relationships with competing entities inside the building.
Point #9: Care Transitions

An Emerging, Important Metric

Care transition programs are increasing from 30 days toward 12 months. They are moving from isolated vertical towers like acute or SNF environments to flat horizontal models focused on integration and efficiency of quality outcomes. We suspect a good model in the future for the patient and a revenue-focused holistic approach will include coordinated services for a lifetime.

Everyone will tell you there is no revenue or payer source. We found when we removed our blinders created by the current system, we discovered incredible opportunities. It requires a fresh approach…a fresh set of eyes and a willingness to overcome fear and look at the event horizon more openly and without bias or filters.

Biggest Challenge…and Opportunity

We started a transition program where case managers, social workers, marketing staff and transition people work collaboratively in the moment and on the fly. Out of everything we have worked on, fretted about, experimented with and driven quantum change—transitions have been without exception the most challenging. We believe it is also where the most opportunity exists now and in the future. The amount of change and resistance we have in this area requires constant leadership. Don’t underestimate it, and don’t be afraid to try and fail with incremental changes. Our innovations come from failure more than just success.
Point #10: Contracting Expert

As AccentCare’s CEO Steve Rodgers commented at the LTC100 Leadership Conference, “You must have some really good contracting people in your organization. Pick your partners well.”

While we can offer advice based on our own experience, we encourage you to hire a contracting expert. The folks across the table from us can afford top talent. They negotiate very big deals with very big partners who are a lot larger than we are.

Honesty, Transparency, Humility

We hear lots of talk about contracting strategies and positioning. Our approach is simple, but fundamental:

- Be direct in our expectations and needs
- Be clear about our capabilities and weaknesses
- Be transparent in sharing what is traditionally confidential internal or proprietary information
- (Above all) Have genuine humility, which we believe to be the key builder of trust

Much More Than a Contract

At the end of the day, contracts are for worst case scenarios, not operating. As we build trusting relationships with our partners and if the partners perform to the intended levels, it all works. If there is a lack of trust, or if you are a vendor rather than a partner, then the contract is not worth the paper on which it is written—other than to hold up in court when you are claiming to have been victimized.

Use experts and stay within your capabilities. It is just common sense.
About the Author

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As CEO of Shea Family since 2010, Ken Lund guides strategic planning, operations, company performance and leadership of the company. Ken and team are repositioning the company into a true post-acute recovery continuum, by adding complementary businesses and support services that function as independent profit centers while enhancing continuity of care.

Ken has 30 years of experience in top management in industries ranging from banking to commercial real estate to nationwide distribution and has spent the last 15 years revitalizing senior living and skilled nursing companies using a lifestyle and service-based approach.

Ken has a BBA in Finance and Human Resources from Pacific Lutheran University in Tacoma, WA.

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