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Case Study Series

Managing Payor Mix in Behavioral Healthcare – A Case Study

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Abstract

In behavioral healthcare, inpatient facilities must increasingly look to manage the ratio of their payors in order to balance the costs of providing care for insurance providers with lower rates and for charity care. Although volume and reimbursement rates are key to these analyses, other tangible and intangible costs can be associated with different payors. This case study examines the situation facing Good Health Hospital, a behavioral health facility with a large percentage of its payor mix dependent on a local Medicaid MCO. The leadership of the hospital must weigh the benefits of the high volume with the reimbursement rates and other associated costs to determine a course of action.

Keywords: Behavioral Health, Hospital, Medicaid, Payor Mix

Background

Good Health Hospital is an inpatient psychiatric facility founded in the early twentieth century by an order of Catholic sisters to provide care for people living with mental illness. Throughout the most of its history it operated as a nonprofit hospital, becoming well-known for innovative, quality care. Changes in managed care in the 1990s placed serious financial strain on the hospital, and created new challenges for its leadership: although the hospital was adept at providing care, managing the increasingly complex landscape of third-party payors and the demands they placed on behavioral health providers' negatively impacted profitability. Additionally, new regulatory requirements and the challenges of integrating them into a well-established hospital proved too much for the order, and majority ownership of the hospital was sold in 1997. The buyer, Hospital Systems Corp, is an experienced operator of behavioral health facilities with hospitals in 20 US states. Shortly after purchasing Good Health Hospital, Hospital Systems Corp brought in leadership with advanced knowledge of the regulatory and insurance systems, as well as funding several long-needed capital improvements. As a result of Hospital Systems Corp's intervention, the facility was modernized, and restored to a position of prominence within the community. Last year, the hospital billed 43,800 patient days for net patient service revenue of $26.1 M, and is on track to be close to these numbers for the current year.

One strategy for improving census that Good Health Hospital undertook after the acquisition was to increase its participation in the Medicaid program. Like many urban areas, the country in which the hospital is located, has a "carve-out" for behavioral healthcare services: under this system, all behavioral healthcare benefits for Medicaid recipients are administered by a separate Managed Care Organization, American Behavioral Care (ABC). ABC is responsible for providing pre-authorization for patients being admitted to Good Health Hospital, and for conducting concurrent reviews in which the hospital must request additional days to be approved once the existing approved days have elapsed. Because ABC, like most public and commercial insurance providers, does not use a capitated system of payment for behavioral healthcare, higher lengths of stay are beneficial for Good Health Hospital. Given that the patients tend to benefit from the additional days as well, the hospital works hard to justify and advocate for higher lengths of stay from all of its payors. The hospital's Utilization Review (UR) staff have a high success rate obtaining approvals, which has resulted in an average length of stay (ALOS) higher than other providers in the county and the rest of the state (see Table 1). When, however, continued approval from ABC is not obtained, Good Health

Hospital ends up having to write off the days as charity if the patient needs to remain in the hospital. Unlike other payors, ABC's contract includes stipulations that the hospital cannot charge its members out of pocket for care for which ABC had denied payment.

Table 1. Average Length of Stay (ALOS) for Good Health Hospital versus Average (in days)

	ABC	Medicare	Commercial
Good Health Hospital	10.5	8.9	8.2
County Average	9.1	8.1	7.5
State Average	9.4	8.2	7.6

Challenges

Good Health Hospital's strategy of courting additional business from ABC was effective in stabilizing the hospital's revenues and helping to reestablish its prominence. Due to the high number of people covered by ABC in the area, ABC has proven a consistent source of patients and has helped the hospital to operate at a high occupancy. The percentage of ABC patients in the hospital's payor mix has steadily grown, and is currently close to 50%. Additionally, the hospital began to get a reputation of being capable of helping some of the most challenging patients, who are often ABC members. The increased volume of ABC patients has included additional challenges, some of which were present from the start, and some of which have developed over time.

The most critical challenge is that ABC pays a lower daily rate than Medicare and the commercial insurance companies with which Good Health Hospital contracts. Although noticeable at first, this gap has widened over the past several years, due to the fact that ABC has agreed to fewer and smaller rate increases than the other payors. Since the services provided to patients are identical regardless of their payor, the cost of services per patient is the same for this group, leading to a smaller profit margin. Another concern is that ABC is more likely to deny days than the other payors, which must then be written off as charity. (See Table 2 for payor mix, rates, and write off percentages for ABC, Medicare, and Good Health Hospital's top four commercial payors by volume).

Table 2. Payor Mix, Reimbursement Rate, and Percentage of Days Written Off

	Volume (of pt days)	Rate (per day)	Charity and Bad Debt
ABC	46.5%	$520	5.7%
Medicare	8.0%	$750	2.0%
Commercial A	9.4%	$708	1.4%
Commercial B	8.2%	$782	1.8%
Commercial C	6.7%	$688	2.4%
Commercial D	6.2%	$697	3.1%

Another challenge is that ABC has attempted to manage expenses by more aggressively controlling approved days. Although they initially approved up to 7 days at a time, the current trend has been to require a concurrent review every 3 days for most patients. The additional requirements for reviewed have necessitated the UR department adding 1.6 FTE worth of staff hours to handle the higher volume of work for ABC patients. The total cost of this increase is $83,200 per year. Additionally, the fact that the ABC tends to cover

individuals with more severe and chronic mental illnesses exposes the hospital to additional financial and legal liabilities. Although property damage is relatively uncommon, a disproportionately high percentage (62.1%) of damage to the hospital's physical plant has been caused by ABC members. The hospital spent $1.5 M mitigating damage caused by patients in the past year. The more aggressive patients have also resulted in a higher rate of mechanical restraints (2.5 per 1,000 patient days versus 1.4 for other payors).

Additional, non-quantifiable costs are associated with servicing such a high volume of ABC members as well. Compared to other payors, ABC has a more involved certification process, which involves several yearly inspection surveys at the hospital, which require staff time to prepare for and take away from other day-to-day operating activities. ABC maintains a schedule of regular meetings at their offices which members of Good Health Hospital's leadership team are expected to attend, and the hospital's physicians are required to provide additional documentation on many patients to satisfy continued medical necessity in order for UR staff to obtain approval in their concurrent reviews. Although each of these costs are associated with any payor, the CFO estimates an additional cost of $150,000 per year associated with the administrative demands of ABC.

The Scenario

As an expert in hospital finance and payor relations, the CEO and CFO of Good Health Hospital have brought you in to consult on the challenges posed to the hospital by the current payor mix. The CEO is concerned that the hospital's over reliance on a single payor could put it in danger if the leadership at ABC makes any changes to its reimbursement system. The CFO is focused on the effects of the lower rate and the high allowances necessary for charity care of ABC members. Both acknowledge that maintaining a high occupancy rate is a priority for the hospital, and that ABC has been a key part of past success in this area. The question at the heart of this issue is whether or not to shift the resources of the hospital's marketing department towards other payors.

Due to the fact that patients from commercial insurance companies are generally referred by different providers in the community, and that staff would need to focus on building the relationships between Good Health Hospital and the commercial insurance companies, any attempt to shift the payor mix would come at the likely expense of some of the business coming from ABC. The budget for the marketing department has already been set, and staff and other resources that would be used to increase business from commercial payors would have to be redirected from ABC. The Director of Marketing believes that such a shift could lead to a reduction in volume from ABC of 25%. She also projects that a 25% increase in volume from the top four commercial insurers is possible. The hospital's COO is in favor of the shift, and he tells you that he feels the CFO's estimate of incremental administrative costs associated with servicing ABC is overly conservative, and he guesses it is closer to $250,000. Finally, you speak to the Director of UR, who tells you that the additional 1.6 FTE in her department could be reduced to 1.0 (for a savings of $20,800 per year) if the volume from ABC were reduced to 35%.

The CFO is eager to embrace a strategy focusing on payors offering higher rates. The CEO is interested in pursuing a strategy which will improve the profitability of the hospital, but is worried that any reduction in overall volume from a steady source of patients like ABC could jeopardize the long-term stability of the hospital.

Questions

Q1. Compare ABC, Medicare, and the four top commercial payors. What are Good Health Hospitals total revenues from each?

Q2. Assuming the Director of Marketing's projections were correct, what would be the consequences of switching Good Health Hospital's strategy to focus on the commercial insurers?

Q3. How would it affect this decision if the changes in volume were different?

Q4. What are some factors which have not been accounted for in these analyses which hospital leadership may want to consider when deciding how to manage their payor mix?

Q5. Considering all of the issues discussed in the case thus far, what recommendation would you make to the CEO and CFO from Good Health Hospital?

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