avoiding revenue loss due to ‘lesser of’ contract clauses

When establishing new service charges in a hospital’s chargemaster, it is important to be mindful of the potential for lost revenue due to lesser-of-charge-or-fixed-fee clauses in payer contracts.

Standard industry practice has been to establish charges in the chargemaster for new services at some multiple of the Medicare fee schedule or ambulatory payment classification (APC) amount. This practice, combined with the realignment of charges to become more rational, has caused hospitals to lose hundreds of thousands of dollars in payments—often unknowingly.

Hospital finance managers, including those responsible for the chargemaster pricing and contract management, should perform annual analyses using sophisticated financial models to ensure that net revenue is not lost due to payer contract clauses that stipulate the payer has the option of paying the lesser amount between the identified charge and its own fixed fee for a given service.

**Why Charge Setting Can Cause Hospitals to Lose Money**

It has become a nationwide industry practice for hospital finance managers to establish the price for new items added to their chargemasters at a multiple of between two and three times the Medicare fee schedule amount or APC amount whenever the new service can be mapped to a HCPCS code. In fact, this practice has been in place for more than a decade, and today—with Medicare payment rates lagging far behind what we would call reasonable reimbursement based on cost or customary charges—it is clear that this multiple is far too low.

Most rates for Blue Cross, Aetna, United, Cigna, and other commercial or managed care payers are between three and six times the Medicare rates, as is reflected in the non-Medicare-payer fee schedule amount shown in the exhibit on page 2, which is based on actual contract data. As a result, hospitals are being paid less than would be allowable by payers that have inserted lesser-of-charge-or-fixed-fee clauses (or, more simply, lesser-of-clauses) in their contracts for those services priced at a lower multiple of the Medicare rates. It is not uncommon for hospitals of fewer than 100 beds to unknowingly incur as much as $1 million in lost net revenue annually due to such clauses.

Further exacerbating this situation is the increased pressure on hospitals to lower or realign charges to be more rational and defensible. With payers, state agencies, consumer advocacy groups, and the Centers for Medicare & Medicaid Services...
(CMS) publishing hospitals’ average charges per DRG, room rates, and chargemasters, and after *TIME* magazine’s March 14, 2013, cover story by Steven Brill, “Bitter Pill: Why Medical Bills are Killing Us,” which focused on hospital charges, it is clear that hospitals have good reason to undertake chargemaster pricing initiatives and carefully scrutinize their pricing decisions.

But with any realignment of an organization’s chargemaster, it is imperative that finance managers also model the impact of the new and current prices against their organizations’ payer-specific rates where lesser-of clauses apply and then adjust the final new prices before they are implemented.

Hospital finance managers also would be financially prudent to run reports using payers’ historical claims data to identify the average and minimum charges for any cases in a 12-month period, sorted for each of these classifications, to support negotiations with payers regarding the setting of DRG, APC, per diem, ambulatory surgery center (ASC), emergency department (ED), fee schedule, or other fixed rates. With such analyses in hand, finance leaders can ensure that their organizations negotiate to set rates between the minimum and average, instead of accepting rates that are below the minimum charge.

The significant rise in the use of DRGs, APCs, ASCs, and other bundled and packaged rates by payers is perhaps the single most important reason that hospital finance managers should act quickly to implement the systems required to monitor charges and reduce or eliminate the possibility of lost revenue due to lesser-of issues. The fact that lesser-of clauses are common in payer contracts that govern payers’ policies regarding any of these fixed-fee methods only adds to the need for hospitals to implement claims-level systems and analytics to facilitate the precise calculation of charges per item (e.g., per DRG, per APC, per ASC) by payer and at the plan code and patient levels to determine whether any cases have charges below the fixed rate. If cases are found to be below the fixed rate, further analysis will be necessary to identify those services and codes that may require an upward adjustment to reduce or eliminate this issue of lost revenue.

The good news is that the processes for identifying lost revenue due to lesser-of clauses and the solution to this problem are fairly straightforward.

**How to Identify and Solve the Problem**

It should be stressed that the solution to this problem is not to simply raise prices indiscriminately. Simply raising charges across the board would be unwise, given the media’s attention to the reasonableness of hospital chargemaster prices, as evidenced in the March 2013 *TIME* cover story and CMS’s wide release of information on hospital charges.
Another reason that hospitals should not institute an across-the-board price increase is that the loss of revenue probably can be stemmed more effectively simply by adjusting a handful of service code prices, and such isolated adjustments would probably not be made with sufficient precision using an across-the-board approach.

More important, charges should remain both rational and defensible, while also yielding optimum financial returns. Accordingly, prudent healthcare financial management dictates that current chargemaster pricing be developed taking into account parameters such as unit cost (if it is available or can be developed easily), custom market–peer–group data, fee and APC schedules, and contract payment terms. Then, pricing model adjustments should be finalized to reduce, prevent, or eliminate losses due to lesser-of-contract clauses at the service code level. It also will be necessary to model, at the claims level, the net revenue impact that the new prices would have on the lesser-of criterion. Based on the results, individual line-item (service code) adjustments then can be made to prevent payment from being lost.

To illustrate, the exhibit on page 2 lists actual Medicare fee schedule rates and payer rates for a hospital, where the hospital has set its charges at 2.5 times the Medicare fee schedule rate. Note that under this scenario the hospital still would be paid below the payer’s fee schedule and would lose revenue where lesser-of-contract clauses are in effect.

In establishing new prices in the chargemaster, a floor price of 2 or 2.5 times the Medicare fee schedule is still recommended—but only in conjunction with a floor price of at least 1.1 times the highest non-Medicare fee schedule rate. This approach ensures that no line-item prices will fall below the contractually agreed-upon fee schedule rates. However, as discussed previously, it also will be important to perform claims-level analysis to determine the extent to which bundled charges for bundled fixed rates for services such as ED visits or same-day surgery are, for some claims, falling below the negotiated rates.

The exhibit on page 3 presents a simple example showing not only why a claims-level analysis is important to identify lost revenue related to application of the lesser-of clause to bundled payment rates (e.g., all-inclusive ED or same-day surgery per-visit rates), but also what is involved in performing such an analysis. The exhibit indicates that, for a specific payer, the hospital has negotiated a bundled rate for emergency services in the amount of $14,500 to cover all ED and ancillary department services provided to the patient. Unfortunately, in each of the four cases shown, the total charge amounted to less than the negotiated rate because either utilization or the hospital’s line-item charges fell short of what is allowable. As a result, due to a lesser-of clause, the hospital’s payment is $7,100 less than the negotiated rate for just these four claims. By drilling down at the service code level, finance managers may uncover charges that are below market norms, below fully allocated unit costs, or below the hospital’s highest

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**SAMPLE CLAIMS-LEVEL ANALYSIS TO IDENTIFY TARGETED CHARGEMASTER SERVICE CODES TO ADDRESS “LESSER OF” LOST REVENUE FOR BUNDLED RATES**

<table>
<thead>
<tr>
<th>Claim</th>
<th>Emergency Department Bundled Contract Rate</th>
<th>Total Covered Charges</th>
<th>Lost Revenue = Total Covered Charges Minus Bundled Rate Where Charges Are Below Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$14,500</td>
<td>$14,200</td>
<td>$(300)</td>
</tr>
<tr>
<td>2</td>
<td>$14,500</td>
<td>$12,200</td>
<td>$(2,300)</td>
</tr>
<tr>
<td>3</td>
<td>$14,500</td>
<td>$11,800</td>
<td>$(2,700)</td>
</tr>
<tr>
<td>4</td>
<td>$14,500</td>
<td>$12,700</td>
<td>$(1,800)</td>
</tr>
<tr>
<td><strong>Total Lost Revenue</strong></td>
<td></td>
<td><strong>$(7,100)</strong></td>
<td></td>
</tr>
</tbody>
</table>

It is important that this analysis be performed only on those claims that already have been identified as having total covered charges below the contracted bundled rate and as therefore being subject to “lesser of” lost revenue.
commercial fee schedule, and that should be increased accordingly. Such an increase can reduce or eliminate the loss.

**Key Steps**

To avoid lost revenue due to payer lesser-of issues, finance managers should undertake a process that includes the following eight steps.

Identify all payer contracts containing a lesser-of clause. For all contracts that include such a clause, the finance manager should summarize by plan code and patient type the extent to which the clause applies to individual line-item charges or fee schedules (or if it applies to bundled rates). The finance manager also should summarize the bundled rates, and if applicable, which revenue codes are included in the bundled rates. For nonbundled rates, the fee schedules will need to be gathered in an electronic format for Excel reporting and analysis.

Prepare a lesser-of lost-revenue report for nonbundled rates. This report should clarify the extent of any risk of lost revenue under the organization’s current charge structure, and it involves an analysis like that shown in the exhibit on page 2.

Prepare a lesser-of lost-revenue report for bundled rates. Like the previous report, this clarifies the extent of any risk of lost revenue under the current charge structure. The analysis involves a claim-level comparison of covered charges included in the bundled rate to the negotiated rate, as shown in the exhibit on page 3.

For claims found to have covered charges below the bundled rate, identify service codes associated with the greatest proportion of total gross revenue and determine the new, higher charge levels for those service codes to eliminate or reduce exposure to lost revenue. Establishing the charges at least 10 percent higher than the bundled rate is recommended to reduce the risk of lost revenue resulting from changes in other service codes or utilization of services.

Establish an approach for setting charges for non-bundled fee schedules to address lost-revenue-related issues identified in the second step above, keeping in mind the new charge level required to eliminate or reduce the risk of lost revenue. Finance managers should consider establishing a minimum floor price at 2.5 times the higher of the Medicare fee schedule or the highest commercial fee schedule amount plus 10 percent, where the volume for the respective payer plans is at least 10 per year for the patient type to which the fee schedule applies.

Incorporate changes into overall strategic or hospital zero-based pricing modeling and parameters. Finance managers should incorporate these steps into their existing pricing parameters, which may include criteria such as unit costs marked up, peer group corridors, and overall gross and net revenue objectives. For example, if the lesser-of impact analysis shows lost revenue and if increasing the current price to the higher of 2.5 times the Medicare fee schedule or 110 percent of the highest commercial fee schedule would still leave the price too far below the market and actual costs (after consideration of overhead, bad debt, payer shortfalls, and a margin), there may be justification for increasing the charge even higher. Conversely, if the new charge based on the higher of 2.5 times the Medicare fee schedule or 110 percent of the commercial fee schedule is too high compared with the market data, the better option may be seek to reduce the loss rather than to eliminate it.

Update and maintain this rational-pricing process at least annually. With fee schedules, bundled rates, utilization and practice patterns, contract terms, unit costs, and peer data changing each year, it is important to perform this analysis and rational pricing annually to ensure that gross and net revenue levels continue to be both optimum and defensible while falling within allowed contract terms and rates.

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