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EIGHT STEPS TO REVEAL INCREMENTAL REVENUE AND REDUCE RISK RELATED TO "LESSER-OF" AND "STOP-LOSS" CONTRACT CLAUSES

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Restructuring of the hospital's chargemaster in this era of transparent pricing often results in material increases and decreases in line item charges to align with market norms, unit costs, or a hybrid thereof. It is important, as part of this process, to identify or estimate the financial opportunity or risk that the current and new chargemaster prices trigger under lesser-of-charge (versus case rates and non-case rates) and stop-loss clauses in payer contracts.

Content Summary

Healthcare organizations seeking to avoid or recover lost revenue attributable to lesser-of-charge versus fixed-fee and stop-loss clauses in their contracts should:

- Identify payer contracts that contain lesser-of and stop-loss clauses.
- Prepare lesser-of lost revenue reports for non-case and case rates.
- For claims with covered charges below the case rate, identify service codes associated with the greatest proportion of total gross revenue and determine new higher but defensible charge levels for those codes.
- Establish an approach for setting charges so they are not below non-case rate fee schedules.
- Incorporate changes into overall strategic or hospital zero-based pricing modeling and parameters.

Historically healthcare organizations establish chargemaster prices 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 or sometimes millions for health systems—often unknowingly.

Those responsible for the chargemaster pricing or contract management should perform annual analyses using sophisticated financial models. These annual analyses aim to ensure 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 or that higher reimbursement based on a percentage of charges will be paid to outliers based on stop-loss provisions. Often healthcare organizations will uncover new incremental revenue opportunities the first time this analysis is performed.

Reducing Net Revenue With New Chargemaster Prices

It has been industry practice for decades to establish the chargemaster price for new items or services at a multiple of two and three times the Medicare fee schedule or ambulatory payment classifications (APC) amount whenever the new service can be mapped to a Healthcare Common Procedure Coding System (HCPCS) code. With Medicare payment rates lagging far behind, for far too long, what we would call reasonable reimbursement based on cost or customary charges, this multiple is far too low.

Typically, Blue Cross, Aetna, United, Cigna, and other commercial or managed care payer fee schedules are between three and six times the Medicare rates, as is reflected in the non-Medicare-payer fee schedule amount shown in Table 1, 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 more than 200 beds to unknowingly incur as much as $1 million in lost net revenue annually due to such clauses and smaller hospitals between $50,000 and $250,000 a year.

With increased pressure on hospitals to lower or realign charges to be more rational and defensible, financial risk is certainly heightened. With payers, state agencies, consumer advocacy groups, and the Centers for Medicare & Medicaid Services (CMS) publishing hospitals' average charges per diagnosis-related group (DRG), room rates, and chargemasters, hospitals have good reason to undertake chargemaster pricing initiatives and scrutinize their pricing decisions.

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

It would be financially prudent to run reports using payer specific historical claims data to identify the average and minimum charges for any cases in a 12-month period. These reports should be sorted by DRG, APC, per diem, ambulatory surgery center (ASC), emergency department (ED), fee schedule, and other fixed rates to support negotiations with payers.

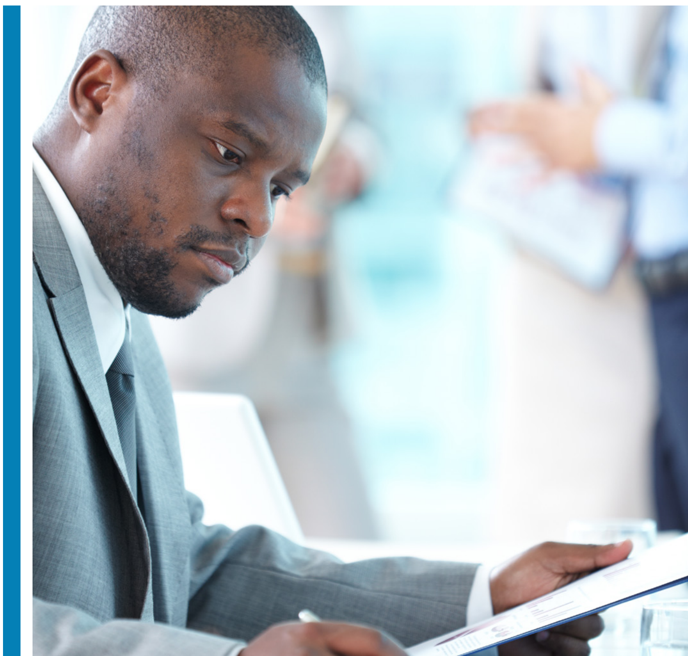
With such analyses in hand, finance leaders can ensure their organizations negotiate to set rates between the minimum and average, instead of accepting rates that are below the minimum charge.

The significant rise in the use of DRGs, APCs, ASCs, and other case and packaged rates by payers is perhaps the single most important reason hospital finance managers want to act quickly to implement the systems required to monitor changes 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 grouper, per case rate, etc.) by payer 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 that may require an upward adjustment to reduce or eliminate this issue of lost revenue.

Fortunately, the processes for identifying lost revenue due to lesser-of clauses and stoploss provisions to solve this problem are straightforward.

Identifying Lost Revenue and Fixing the Leaks



It must be emphasized 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 myriad of unfavorable national, regional, and local press on hospital charges. Lost revenue can be recovered more effectively by adjusting a handful of service code prices. Such isolated adjustments would probably not be made with sufficient precision using an across-the-board approach.

It is imperative that charges remain both rational and defensible, while also yielding optimum financial returns. Prudent healthcare financial management dictates that current chargemaster pricing development must consider parameters such as:

- Unit cost (if it is available or can be developed easily)
- Custom market peer group data
- Non-Medicare and Medicare fee and APC schedules
- Contract payment terms

Then, pricing model adjustments should be finalized to reduce, prevent, or eliminate losses due to lesser-of contract clauses or stop-loss provisions at the service code level.

It also will be necessary to model, at the claims level, the net revenue impact the new prices would have on the lesser-of and stop-loss criterion. Based on the results, individual line-item (service code) adjustments can then be made to prevent payment from being lost. For this reason, itemized bill-level (not 837 or Uniform Bill level) claims analytics is preferred. Ideally, prior to the analysis the new proposed chargemaster prices will be used to create a simulated set of itemized bills by overlaying the new charge over the historical charges for a twelve-month period.

Table 1 Inadequacy of Establishing New Chargemaster Charge at 2.75x Medicare Fee		Values
Chargemaster Service Code: 3412378	CDM Description: Basic Metabolic Panel	HCPCS Code: 80048
Medicare fee schedule:		$10.91
New chargemaster service charge @ 2.75x Medicare fee amount		$30
Non-Medicare-payer fee schedule amount		$48
Amount the new charge is above/below non-Medicare fee schedule		-$18
Amount the new charge is above/below market average of $155		-$125
Annual usage for payer and patient type where lesser-of clause applies		11,700
Annual usage for payer and patient type where percentage-of-charge reimbursement exists		1,780
Annual loss due to charge below non-Medicare fee schedule (-$18.00 x 11,700)		-$210,600
Annual loss in charge payer reimbursement (-$125.00 x 1,780)		-$222,500
	Total Lost Revenue Due to Underpricing	-$433,100

To illustrate, Table 1 lists actual Medicare fee schedule rates and payer rates for a hospital, where the hospital has set its charges at 2.75 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 2.75 or 3.0 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. If non-Medicare fee schedules are not readily available, it would be financially prudent to apply a floor markup factor of 4 or greater instead of 2.75 to 3.0. This approach ensures that no lineitem prices will fall below the contractually agreed-upon fee schedule rates. However, as discussed previously, it will also be important to perform claims-level analysis to determine the extent to which charges for fixed case rates for services such as ED visits or same-day surgery are, for some claims, falling below the negotiated rates.

Table 2

It is important that this analysis be performed only on those claims that have already been identified as having total covered charges below the contracted case rate and as therefore being subject to "lesser-of" lost revenue.

Sample Claims-Level Analysis to Identify Targeted Chargemaster Service Codes to Address "Lesser Of" Lost Revenue For Case Rates			
	Emergency Department Case Rates	Total Covered Charges	Lost Revenue = Total Covered Charges Minus Case Rate Where Charges Are Below Rate
Claim 1	$14,500	$14,200	-$300
Claim 2	$14,500	$12,200	-$2,300
Claim 3	$14,500	$11,800	-$2,700
Claim 4	$14,500	$12,700	-$1,800
		Total Lost Revenue	-$7,100

Table 2 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 case 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 sample analysis indicates that, for a specific payer, the hospital has negotiated a case 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 the hospital's line-item charges or utilization 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 commercial fee schedule, and these should be increased accordingly. Such an increase can reduce or eliminate loss. Stated differently—new incremental net revenue will be recovered.

Eight Action Steps to Recovering Revenue

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

1. Identify all payer contracts containing a lesser-of clause.
For all contracts that include such clauses and provisions, the finance manager should summarize by payer and patient type the extent to which the clause applies to individual line-item charges or fee schedules (or if it applies to case rates). The finance manager should also summarize the case rates, and if applicable, which revenue codes are included in the case rates. For Current Procedural Terminology (CPT)/HCPCS-level rates, fee schedules and per unit rates will need to be gathered in an electronic format for Excel reporting and analysis.

2. Prepare a lesser-of lost revenue report for non-case rate CPT/HCPCS-level fee schedules and per unit 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 Table 1.

3. Prepare a lesser-of lost revenue report for case 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 case rate versus the negotiated rate, as shown in Table 2.

4. For claims found to have covered charges below the case 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% higher than the case rate is recommended to reduce the risk of lost revenue resulting from changes in other service codes or utilization of services. Services should be reviewed to determine whether the market can justify the increase in price.

5. Establish an approach for setting charges for CPT/HCPCS-level fee schedules and per unit rates 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 2.75 to 3.0 times the higher of the Medicare fee schedule or the highest commercial fee schedule amount plus 10%. This is advisable anywhere the volume for the respective payer plans is at least 10 per year for the patient type to which the fee schedule applies.

6. Consider the volume of cases falling below the "stop-loss" threshold.
As illustrated in the claim example in Table 3, identifying the number of cases falling slightly below the "stop-loss" threshold can prove to be productive. This is especially true where the charge levels are due to prices being below market average, cost, or other defensible price benchmark levels. Raising prices to defensible and competitive, yet financially optimal, levels makes sense for any business.

Table 3	Criteria	Values
	DRG case rate (non-stop-loss)	$25,000
	First dollar stop-loss rate	70% Of Billed Charges
	Stop-loss threshold	$100,000
	Current claim charges	$99,000
	Adjusted claim charges	$101,000
	Current reimbursement (DRG case rate)	$25,000
	Adjusted claim reimbursement (stop-loss rate)	$70,700
	Change in reimbursement $	$45,700
	Change in reimbursement %	+183%

Based on the claim example in Table 3, identifying and increasing select services that are below cost or market averages or are a hybrid thereof by only a marginal percent can have a big impact on your hospital's bottom line.

7. Incorporate changes into overall strategic or hospital zero-based price modeling and parameters.

Finance managers should incorporate these steps into their existing pricing parameters, which may include criteria such as unit costs mark-ups, 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 2.75 times the Medicare fee schedule or 1.1 times 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 2.75 times the Medicare fee schedule or 1.1 times the commercial fee schedule is too high compared with the market data, the better option may be seeking to reduce the loss rather than to eliminate it.

8. Update and maintain this rational-pricing process at least annually.

With fee schedules, case rates, utilization, practice patterns, contract terms, unit costs, peer market data, and strategic objectives changing each year, it is important to perform this analysis and rational pricing annually to ensure gross and net revenue levels continue to be both optimum and defensible while falling within allowed contract terms and rates.

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