Managing Lesser Of Contract Terms

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Seth Avery
President and CEO
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1

Presenter: Seth Avery

Seth Avery has over 25 years of experience as a healthcare executive, serving as auditor, consultant, Administrator and Chief Financial Officer (CFO). Mr. Avery has served as the CFO for a major teaching hospital in Texas and as the Executive Director of a leading New Jersey Medical School. He has worked at government, for-profit, and not-for-profit health care providers, as well as at a Big 6 organization.

Seth has been certified by the American Academy of Professional Coders (AAPC) as a Certified Professional Coder (CPC) and is a past member of the National Advisory Board for the AAPC. Seth has a B.S. from Campbell University, an M.A. in Economics from the University of New Mexico and a Juris Doctor from Texas A&M University. Seth is also a 14-year veteran of the U.S. Military, serving both as a member of 5th Special Forces Group and as a Medical Service Corps officer.

He is a frequent speaker at Healthcare Financial Management Association conferences and presents webinars providing education on various healthcare finance topics.

savery@apprev.com

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2

Agenda

- Introduction
- Lesser Terms
- Outpatient
- Inpatient
- Measuring Success

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What is "lesser language"?

- When a provider agrees to accept the lesser of the billed charges or the negotiated rate.

- Typically the billed charge is compared to a fee schedule amount or inpatient case rate.

- Varies from state to state insurance market.

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4

Why does lesser of matter?

- Typically hospitals suffer "lesser of" losses.

- It may be difficult to understand the scope of the problem.

- Every dollar that is charged under the threshold is a potentially lost dollar.

- Hard to take when you are already discounting 40-60% to the payer.

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5

Complications in the calculation

- Outpatient lesser of can be found at two levels:
  1. Service (most common)
  2. Claim Charge

- **Service level:**
  Each service is compared to its own fee schedule amount.

  - If the charge is less, you get paid the charge amount.

  - If the charge on one item is greater than its fee schedule, it has no impact on the one that is below.

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6

Complications in the calculation

Claim level:

In this method, total charges on the claim is compared to the total expected payments from the fee schedule.

Service	Contract Rate	Charge	Service level	Claim level
X-Ray of the chest	$100	$80	$80	$100
CBC test	$24	$45	$24	$24
Total	$124	$125	$104	$124

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7

Inpatient

Typically there is single payment for a case rate.

- MS-DRG, APR, or even per diem

- Total charges compared to the case rate

- You need to understand how carve outs impact this calculation.
    - Do the charges for a "carved out device" and the payment count in the calculation?

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Inpatient

- It is common for lesser of cases to be very short inpatient stays.

  - Based on my experience, the vast majority are premature babies with complications and major complications. (MS-DRG 791 and 792)

- It is important to identify the lesser of cases for analysis.

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Inpatient Analysis

1. Which payers have lesser of language?

2. Select the inpatient accounts for these payers.

3. Data elements required:
   - Payer
   - Account number (or reference number)
   - Charges at the revenue code summary level
   - DRG or case rate indicator
   - Length of stay
   - Discharge status
   - ICD-10 Diagnosis and procedure codes

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Inpatient Analysis

Compare the case rate to total charges:

1. If the charges are less than the case rate, then you have found the lesser of case.

2. Make sure that you understand how the carve outs work:
   - Should those charges be included in the total charges or not?
   - Should the carve out payment be added to the case rate?

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Inpatient Analysis

It's the opposite of the 80/20 rule:
- It's generally a small number of inpatient cases.
- Neonates are typically the big numbers.
- Try using Average Length of Stay or Geometric Length of Stay to spot big differences: (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html)
- Often your big differences are due to short stays for high value MS-DRGs.

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Inpatient Analysis

Coding errors can also drive higher MS-DRGs than expected.

- You can spot these by looking at the length of stay and expected length of stay.

- Discharge Status
  - Discharge status can also effect charges.
  - Was the patient transferred?
  - Did the patient expire?

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13

Carve Out Examples

Example 1

Case Rate	$80,000
Charges (excluding device)	$70,000
Device Charge	$20,000
Total Charges	$90,000

In this example, the device is reimbursed at 60% of the device charge. In this case the payer identified the device charge by totaling the charges in the revenue code 0278.

There are two possible calculations for the total payment:
  1. Case Rate
  2. Lesser of Rate

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14

Carve Out Examples

Example 2

Case Rate	$80,000
Device	$12,000
Total Payment	$92,000

In this payment calculation, the payer has used the total charges to satisfy the lesser of calculation and has added the carve out payment.

Example 3

Lesser of Rate	$70,000
Device	$12,000
Total Payment	$82,000

In the second payment calculation, the payer has excluded the charges paid under the device carve out from the lesser of calculation. As you can see, it is very important to understand how the payer actually calculates this term.

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Pricing Implications

Once the inpatient or outpatient lesser of issues have been identified, the next step is to develop a plan which requires an analysis

✓ It would be awesome if it was as simple as raising the prices to "recover" all of these loses.
  - Typically providers have a limit by payer as to the overall charge increases they can execute every year.
  - The amount of gross charge increase is typically too great to solve the problem.

✓ The good news is that you can target increase and get the best "bang for your buck"!

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16

Pricing Implications: Outpatient

Analysis First

1. Build an analysis that includes:
   - Fee schedule amount for each service
   - Volumes for each service by payer

2. Typically providers will raise prices to meet the fee schedule amount and may offset this by lowering the prices on other services. *This can actually reduce net revenue.*

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17

Pricing Implications: Outpatient

Example:

Assuming that we have a payer cap on our overall price increase of 5%, we had a lesser of loss because the charge was $20 below the contract rate.

Let's say the payer quantity for this service for the year was 100. The lesser of loss would then be $2,000. To eliminate this loss the price would need to be increased by $20 for each one of $2,000 in gross charges.

So far, so good: We have a 100% return on our price increase, but...we have other payers with their own terms and quantitates.

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18

Pricing Implications: Outpatient

X-Ray of the chest	A	B	C	D	E	F
Payer Rates	$100	$40	$100	$70	$80	$60
Quantity	100	300	50	150	100	250
Gross Revenue	$8,000	$24,000	$4,000	$12,000	$8,000	$20,000
Lesser of ?	Y	N	Y	Y	Y	N
Net Revenue	$8,000	$12,000	$4,000	$10,500	$8,000	$15,000
Lesser of loss	**$2,000**		**$1,000**			

Total Quantity	**950**
Total Lesser of loss	$3,000
Total Gross	$76,000
Total Net	$57,500

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19

Pricing Implications: Outpatient

To eliminate the lesser of loss for payer A and C, the price for the service would need to be increased by $20 or 25%. The problem: Doing so increases the rate for all payers.

Because of this we cannot just increase the rate by the $3,000 (150 x $20), but rather we end up with $19,000 (950 X $20). We have exceeded our gross charge increase cap by $15,200 ($76,000 x 0.05 = $3,800).

To make this work we need to decrease prices in other areas by $15,200 to break even.

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20

Pricing Implications: Outpatient

To further complicate things, some payers pay as a percentage of charges (POC). When we lower prices where there are POC volumes, we have a similar impact to lesser of loss. We will experience a POC loss for each dollar of decrease multiplied by the quantity of the payer for the service.

So how do we make this analysis manageable? We calculate the price sensitivity for each service by using the payment term for each specific quantity of service and patient type.

This eliminates the problems associated with across the board price increases, such as payer increases, exceeding gross charge increase cap and taking on POC losses.

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21

Case Study Bon Secours Roper St. Francis

Background

Roper St. Francis
* 150 years old
* Roper Hospital
* Bon Secours St. Francis Hospital
* Roper St. Francis Mount Pleasant Hospital,
* Roper St. Francis Berkeley Hospital (under construction)
* 657 beds
* 800 physicians
* More than 5,700 team members

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22

Lesser of Payers

- Three major payers have lesser of language

- Claim level and service level limitations

- Prices had not been adjusted in several years

- Management felt that there were significant losses

- Current strategic pricing initiative to lower some outpatient prices
  - Lower prices at the service level exacerbated the losses at the claim level

- Unable to determine the net revenue impact of necessary changes

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23

Analytical Approach

- Engage a partner that can calculate the net revenue impact and find gross charge offsets

- Need to calculate the impact of complete pricing strategy, price sensitive and net improvement related to lesser of losses

- Ability to model across multiple payer limitations both at the claim and service level

- Can monitor the impact on the solution once implemented

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24

Case Study
Roper St. Francis

The issue was modeled as first pass of $4.7M in OP losses.

payer	LesserOf	adjLesserOf	difference
Alpha	(1,060,142)	(514,214)	545,928
Bravo	(311,636)	(302,909)	8,727
Charlie	(3,405,656)	(3,240,518)	165,139
total	(4,777,434)	(4,057,640)	719,794

The first iteration improvement suggestion netted a reduction of the lesser of by over $700k by "repurposing" gross charges more efficiently.

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25

Case Study
Roper St. Francis

The issue was modeled as first pass of $9M in IP losses.

payor	LesserOfAmt	adjLesserOfAmt	diff
Alpha	(6,112,247)	(5,282,623)	829,623
Bravo	(2,035,948)	(1,693,156)	342,792
Charlie	(853,387)	(666,140)	187,247
total	(9,001,582)	(7,641,919)	1,359,663

The first iteration improvement suggestion netted a reduction of the lesser of by over $1.4M by "repurposing" gross charges more efficiently.

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Analysis Examples

Inpatient

- 217 DRGs with lesser of losses

- 65 DRGs represent 80% of the total lesser of losses

- 91% of lesser of loss was either discharged to home or transferred to another facility

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27

Results

- By taking charges, decreases, from items that have low charge sensitivity some lesser of is recovered
- Caution must taken in reducing prices illogically
    - Reducing a two view x-ray to less than the corresponding one view
- Every time the strategic pricing model is updated there is impact on:
    - Lesser of
    - Stop loss
    - Percent of charge net revenue
- In the modeled scenario, BSRSF was projected to reduce lesser by over $2M while staying within the over charge limitation

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28

Conclusion

In Conclusion

Because of the many moving parts associated with lesser of reduction, hospitals should approach the issue with caution. Additional complications not addressed in this presentation include outpatient grouper hierarchy, outpatient case rates, grouped services and others.

The impact of this issue also tends to change from state to state. Payers in some states may tend to have more percent of charge and fewer lesser of terms. We also encourage hospitals to adopt technology or processes to detect "hidden" lesser of, much as they would with a silent PPO discount.

With planning, intent and attention to detail, hospitals can develop strategies to reduce lesser of losses.

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29

Lesser Of Article

For more details on Lesser of Language, please see this article by Seth Avery published in the February 2017 issue of HFMA Florida Sunspots Magazine:

https://www.floridahfma.org/sunspots-1/?offset=1486003770155

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Questions/Discussion

31