Strategies for Maximizing Managed Care Revenue Through Analysis and Negotiations

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Never leave money on the table.

This is one of the cardinal rules for any business. For physician practices operating within an economic structure that is dependent upon commercial payors, a major determining factor of business success is the ability to claim the available dollars placed on the market’s proverbial “table.” With a variety of commercial payors and a range of reimbursement rate structures in place, there is a strong likelihood that many physician practices are not maximizing the potential financial return for the services provided to their patients.

The basic business formula for running a physician practice is no different than what is seen in other industries. In today’s cost-conscious business environment, physicians must eliminate waste and maximize productivity within their existing services. Yet, unlike other industries, the physician practice business model receives the overwhelming majority of its revenue from third-party health insurance providers. If a physician practice is operating at peak efficiency from a cost and labor perspective, an argument could be made that the third-party payor rate structure has the power to dictate the rise or fall in the profit margin for the business. (For perspectives on how to review expenses and operate a practice at peak efficiency, please click here).

The process of examining the rate structures of commercial payors can allow a practice to identify opportunities for increasing the profit margin of the business without the expansion of services or personnel. While reviewing negotiated commercial payor rates and the current reimbursements realized by physician practices could reveal a potential for rate improvements, the process is dependent upon finding payor rate gaps and developing strategies to address those opportunities.

The changes in health insurance coverage with the arrival of the Affordable Care Act (ACA) have placed new pressures on practices and rate structures. Meanwhile, the cost of doing business as a practice has not remained stagnant, and practices must consider new approaches for addressing rates. Under the current payor structure established as a result of the ACA, a practice must address key business decisions regarding insurance plans connected to the ACA. From a business perspective, one of the most important evaluations a practice is called to make is whether or not to participate with insurance plans that are part of the ACA. Quite often, the determining factor is found in how the coverage plan benefits the practice.

Rethinking Rate Increases and Examining Allowables

One effective strategy for exploring the possibilities within existing rates is to essentially reverse engineer the process. Rather than simply looking at the rate structure within the list of health insurance providers paying the practice, today’s landscape can be more effectively changed by first looking at the practice’s patients and pooling them within the health insurance providers they utilize.
The examination of rate structures within a practice provides two opportunities. The first is comparing what the practice charges for each CPT code to what is allowed by each insurance company. Insurance companies pay the lessor of the practice’s charge or their allowable. So if a practice were to charge $55 for a certain test and the insurance company’s allowable was $60, then the practice would be leaving $5 on the table for each time they charged for that specific code with the insurance company.

The second opportunity is to compare the total amount to be reimbursed by an insurance company for a specific set of services to what Medicare would pay for the same set of services. For example, if the insurance company is willing to pay $90 for a specific test and Medicare is willing to pay $100 for the same test, the practice is being paid 90 percent of the Medicare rate.

**Third-Party Data Analysis: A Process for Examining Revenue Potential**

Pricing structures within practices and allowable insurance rates among various providers can produce a myriad of randomized data. The Elliott Davis Decosimo Healthcare Team has developed a process which provides a structure to analyze these facts and figures. Structured data and an impartial third-party analysis can provide clarity to the decisions that practices need to make when examining pricing and rates. While clarity allows a practice to make informed decisions that can lead to enhanced profitability, some of the choices and the resulting changes will not be easy.

The process of detailed analysis can be challenging because a practice must decide if it will participate with certain commercial payors and how might it impact patients should it decide to drop certain payors. What will be the guidelines for accepting new commercial payors going forward? How will the practice address the short-term impact of any changes?

A classic example would be the following: A practice is a participating provider with a specific insurance company, but the patient volume is small and the reimbursement is low. While the business decision to no longer participate seems easy to make, the decision becomes complicated due to the fact the physicians have long-standing relationships with several patients covered by this plan. The physicians do not want to put their patients in a position where they could be hurt by the practice dropping the payor. At the same time, the physicians, as business owners of the practice, understand the importance revenue plays in profitability.

With more pressure on the payors to hold down premiums, look for payors to begin looking for price reductions, particularly among the higher paid specialties. Examining payor fee schedules will become more strategic in the coming years.

The process utilized by the Elliott Davis Decosimo Healthcare Team examines commercial payors, allowable rates and relative value units. Through this process, a practice can see how insurance companies compare to each other based upon reimbursement and volume of work. The analysis provided by our Healthcare Team offers practices the opportunity to establish payor rules for the practice that will offer enhanced revenue.

There are five key questions for a practice to consider during this process.

- When was the last time the practice negotiated a fee increase with each payor?
Which payors have been identified as opportunities for improved rates through negotiations?
Which payors should be left alone to avoid risk of being hit with a rate reduction?
Which payors might be dropped due to low and or unmovable rate structures?
Is there opportunity to increase the number of patients seen with favorable reimbursement schedules?

Utilizing Practice Rules as a Guidepost Toward Greater Revenues

By establishing guidelines regarding acceptable levels of reimbursement for services, a practice brings structure to an area of the business that generally lacked structure. With the needed structure, the practice can begin negotiations with payors on rates and business decisions impacting revenue can be made. For instance, the practice can begin negotiating with those payors – as analyzed by their patients’ use of services in the practice – which are paying the practice a lower amount than those payers which bring a greater volume of work to the practice. Using the established guidelines, the practice will know what to propose to the payor and the minimum amount it is willing to accept. If a payor is unwilling to negotiate, the practice would then use the analysis provided by the Elliott Davis Decosimo Healthcare Team to decide whether to drop the payor.

The process of dropping of a payor – one which undervalues the services provided by the practice through low allowables -- is a difficult step for a practice. However, with the analysis provided by the Elliott Davis Decosimo Healthcare Team, the owners of a practice know exactly what insurance companies value the practice’s work and where to find the patients.

Consider the following: A commercial payor in which the practice participates pays 93 percent of the Medicare rate for services the practice provides to the payors’ patients. After extended negotiations, the payor decides the rates it is paying are market competitive. The practice must decide to either continue as a participating provider or drop the insurance company. From the practice’s analysis, it knows the payor accounts for only five percent of the practice’s volume. This level of volume could easily be replaced at the minimum by accepting more Medicare patients. Given these facts, the practice decides that it will notify the payor that in 90 days it will no longer be a participating provider. In response to the notification, the payor becomes serious about negotiations and the practice agrees to rates that are 110 percent of Medicare.

Using the analysis, the practice knew that, at a minimum, it was going to increase its revenue by seven percent if it were to replace the payor’s patients with Medicare. Therefore, the practice was willing to walk away. In taking this position, the practice increased its reimbursement from the payor by 17 percent without having to do any additional work.

The reality of a commercial payor deciding not to negotiate after a termination notice does have the potential for downstream impacts. It brings back the question of losing long-term patients from the practice. However, within today’s insurance coverage landscape, patients have options and, despite a payor not having a practice in network, patients can continue to see their doctors of choice.

By having a clear understanding of how they are being paid for the services provide and by establishing clear guidelines regarding how they want to be paid in the future, physicians in the practice can move
forward with the peace of mind to focus on medicine and the care of their patients.

**We Can Help**

The Elliott Davis Decosimo Healthcare Team has developed a comprehensive program for the examination of payor rates and strategies for delivering higher revenue yields for physician practices. Our team has the expertise to examine the myriad of data involved with practice pricing and allowsables rates of commercial payors, Medicare and Medicaid and allowable rates. We have the knowledge and experience to analyze the pertinent facts, facilitate rate negotiations and assist in the development of guidelines that will enhance profitability. To learn more about how we can help you with implementing strategies to maximize income from managed care, please contact Healthcare Principal Ira Bedenbaugh via [email](mailto:email).