OVERCOMING PERCEPTION

YOU *CAN* RESTRUCTURE PAYER CONTRACTS TO INCREASE REVENUE

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What can physician practices do to better manage a complex regulatory and managed care landscape? *How can you increase revenue while supporting quality outcomes at the same time? The questions have never been more urgent—nor the answers, more evident. Actively managing payer contracts is the key, and the support of R1 RCM is the way.*

CONTENTS

PROTECTING REIMBURSEMENTS FROM NEW THREATS

A well-established and ongoing challenge facing physician reimbursements is value-based care, where income is tied to quality outcomes. But there are other emerging revenue pressures as well. In particular, new legislation regarding out-of-network billing will effectively lower the amount that patients are responsible for paying. As a result, organizations and physicians not in-network could see a significant negative impact on their reimbursements.

The goal of this legislation is to put an end to the horror stories you hear from patients about receiving exorbitant bills for out-of-network services. No one should have to deal with a $100,000 emergency room bill, after all.

This legislation leaves smaller practices especially vulnerable, particularly those that lack the resources and scale to actively pursue in-network contracts. Because the legislation differs from state to state, there's no consistent strategy for addressing it. In Texas, for example, out-of-network costs are directed to an arbitrator, who then determines how much an out-of-network organization or physician owes on a patient-by-patient basis.

What impact could this legislation have, both now and down the line? By limiting the amount that out-of-network providers can bill, patient volume could shrink, which could threaten to shut down important services such as emergency rooms. Perhaps, the facility might need to close its doors altogether.

What is the solution? What specifically can physician practices do to counter this pressure and increase revenue? Practices that are proactive with revenue management will have a clear advantage in a world of declining reimbursement. Finding ways to improve payer contracts seems to be the right place to start. But to succeed, practices must first overcome a prevailing perception about payer contracts—a perception that threatens to stand in the way of success.

THE SOLUTION: RESTRUCTURING PAYER CONTRACTS

For many physicians, it's easy to get caught in the mindset that there's nothing you can do to increase revenue from payer contracting. The reason is twofold. First, the landscape of payer contracting can seem almost impenetrably complex and is constantly changing. Combined with the fact that many practices lack the internal staff and resources to work with payers, it can become difficult to restructure contracts in a way that creates opportunities to improve revenue.

> However, it is more than possible to restructure payer contracts to achieve a higher fee schedule and increase reimbursements. The first step is to realize that current threats to reimbursements—such as the changes to out-of-network payments—can actually be ***opportunities*** for physician practices.

It's all about ***certainty***: once you know what your payments are going to be, you can build a budget and operating plan around projected revenue. You may not necessarily like what those payments are going to be, but they will be guaranteed. And from there, you will have a foundation to begin exploring the extent to which payers are open to restructuring your contracts.

THREE STEPS TO SUCCESS

With that in mind, what can physician offices do to restructure contracts in a way that increases revenue? There are three major steps to consider:

1. KNOW YOUR BUSINESS

What are all the sources of practice revenue? Start by identifying those contracts that represent the greatest percentage of revenue. From there, you will have a basis to begin discussing contract fee structures.

As much as half of a typical practice's reimbursements may come from Medicare and Medicaid alone. While some patients may pay out-of-pocket, the second half of practice revenue will mostly likely be derived from private insurance. On average, roughly 80% of commercial revenue may come from as few as four health plans, and approximately 70% of it may be from just six E & M (Evaluation & Management) codes.

By understanding the big picture of where revenue is coming from, physician practices will be in a better position to identify areas for improvement and have productive conversations with private payers.

2. KNOW YOUR STORY

A physician office can't expect to increase its revenue from private payers without first presenting a persuasive rationale. You can't simply say, "I want more money," and expect to succeed.

It's important to first ask yourself, ***where is your market leverage?*** What advantages do you have compared to other practices in your community and area of specialty? How can those advantages translate into more value for the payer and more attractive reimbursement rates for you?

When you present your rationale to payers, it's also important to conduct these conversations in person to build rapport. Understand that payers know your goal is to increase contract rates, so your rationale must clearly demonstrate mutual benefit. You must articulate ***how*** you're planning to save money.

Remember that coverage criteria are constantly changing, so pay attention to these shifts in order to keep your story fresh and relevant. For example, some payers may change which procedures require prior authorization. If you're unaware of these changes, your story may focus on outdated rationale, and your reimbursement may be negatively impacted.

3. MANAGE THE PROCESS

It's an ever-evolving effort to manage multiple contracts among multiple payers. You can't move an entire fee schedule at once: different codes are on different timelines, so you will likely be juggling multiple expiration dates over time.

That's why it's important to begin discussions approximately four to six months prior to contract expiration. Be sure to pay attention to notices you may receive in the mail from payers that notify you of fee changes by code. Otherwise, you may be surprised by a drop in your reimbursement rate for that code, once the higher fee expires.

Above all, you need to remain in constant communication with payers to manage your contracts. **It's an ongoing process, and collaboration is key to success.**

THERE'S MUCH TO GAIN

At R1 RCM, we collaborate closely with physician offices across the country to support clients to actively manage and restructure payer contracts to their benefit. For example, we helped one Kentucky organization consisting of seven integrated pediatric and adolescent care practices raise their per member per month (PMPM) revenue from $2.85 to $3.35. This shift increased overall practice revenue by $110,000 per year.

To meet the increasing demands of value-based care, we're also helping practices join gain-sharing programs like Anthem's EPHC (Enhanced Personal Health Care) program, adding an additional layer of reimbursement from patients those practices are already serving. States such as North Carolina are leading the way in focusing on value metrics and creating gain-sharing programs that reward providers for costs savings.

HERE'S HOW GAIN-SHARING PROGRAMS WORK:

1. The payer determines a financial baseline for a patient's healthcare each year, based on past expenditures.
2. The provider then focuses on managing the patient's healthcare for the next year at a cost below that baseline.
3. The provider is rewarded by receiving a percentage of any savings achieved.

By focusing on the delivery of value-based care, physician offices can actually ***increase*** revenue and support quality patient outcomes at the same time.

A critical key to delivering care at a cost below the baseline is to avoid emergency room visits. Physician practices can think creatively about ways to achieve this goal. For example, if an $85 wellness visit can help prevent a $2,200 ER visit, then taking a proactive approach to prevention is money well spent. Taking this strategy a step further, some physician practices are opening their own urgent care clinics with evening hours to direct patients away from the higher cost of a visit to a hospital emergency room.

Many physician practices are not aware of these gain-sharing programs. Some payers are proactive about informing physicians about these programs, but in other cases, physicians may need to reach out themselves to be better informed—or to bring gain sharing ideas of their own to the table.

OPPORTUNITY FOR THE FUTURE

Though out-of-network billing legislation creates new challenges for navigating value-based care, physician practices can identify opportunities to increase revenue. They can restructure payer contracts to their advantage—if they know how.

To start, practices need to understand what the sources of their revenue are. Then, increase revenue opportunities by developing a compelling story to present to payers. Finally, realize that actively managing payer contracts is an ongoing process requiring commitment, resources and expertise.

R1 RCM can provide support for all three—so physician practices can focus more on quality patient care.

A FOCUS ON CONTRACT MANAGEMENT CAN PRODUCE MEASURABLE RESULTS

Based on practice demographics, physician specialty and eligibility for quality incentive programs, **the average annual commercial revenue increase resulting from effective contract management can be 4%-6%.**

*Averages from R1 previous client engagements.

ABOUT R1 RCM

R1 RCM is a leading provider of technology-enabled RCM services which transform and solve revenue cycle performance challenges across hospitals, health systems and group physician practices. R1's proven and scalable operating models seamlessly complement a healthcare organization's infrastructure, quickly driving sustainable improvements to net patient revenue and cash flows while reducing operating costs and enhancing the patient experience.

To learn more visit: **r1rcm.com**.