How to calculate payer fee schedules and why this technique is important to avoid leaving money on the table

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2017 is here and moving by quickly. As usual, the healthcare landscape is changing and evolving. To help providers navigate the complex terrain of payer contracting, I am going to be writing about tips that will help you succeed in your payer contracting efforts in 2017. This is the first one in the series and is about how to accurately calculate the value of payer fee schedules to be sure that you don't leave money on the table. Enjoy and prosper in 2017 and beyond.

When you are assessing the percentage of local Medicare rates represented by a payer's fee schedule, in aggregate, or you are trying to determine the "average" rate of reimbursement, it is important to "normalize" the calculation across your fee schedule to take into account the revenue produced by each CPT code, i.e., the volume performed * the payer rate at 100% including patient co-payments / co-insurance etc. vs. the Medicare revenue produced by that code using the same volume. Otherwise, you will work an average which is simply calculated by summing each percentage of Medicare by CPT code and dividing by the total number of codes. This is a hazard and will cause you to almost always overstate, substantially, the relative percentage of Medicare across your agreement(s). This will often distort outcomes since you are not accounting for the revenue importance of each code. Further it is a common mistake to only focus on codes with high volumes or high rates in isolation. Remember, it is the multiplier of rate * volume that drives revenue. A lab code, for example, performed 1000 times at $.5 is only worth $500 while a surgical code performed 1000 times at $1000/surgery is worth $1M. This demonstrates why you need to focus on the revenue value of codes / services.

The problem with using averages, not weighted averages, when assessing a payer's fee schedule is that the average does not consider the relative "revenue importance" of the code. A simple example is a code priced at $1K per service producing $250K of revenue, therefore performed 250 times, which is currently priced at 100% of Medicare while a second code produces $10K of revenue at $10 per service, therefore performed 1000 times at 200% of Medicare. If we average the Medicare rates of these two codes, we get 150%. (200+100)/2. However, the weighted average is only 102% of Medicare ($260,000/$255,000) which is the $\sum$ of the revenue / $\sum$ of the Medicare revenue). Therefore, you can see that the revenue importance of the code that produced $250K of revenue was much higher and, since it accounts for almost all of the service workload dollars, it also must also be reflected in the percentage of Medicare value. It is highly critical that this approach be applied across your entire fee schedule.

The example, below, in Figure 1, illustrates the importance of using weighted averages along with an explanation of the formulas. In this example, the average percentage of Medicare, in aggregate, for the two codes combined is 178.5%. This is what the payer will tell you and this, in fact, is accurate. The only problem is your real average reimbursement, i.e., the weighted average, is actually 137%. This is because when you average the reimbursement across these two codes, the 266% associated with code G6016 is weighted the same as the 91%. What is not

factored in is either the Medicare revenue or the revenue value of the code. In this case, the Medicare rate is higher than the payer rate for CPT code 99213 while the Medicare rate is much lower for CPT code G6016 than its payer rate. Therefore, our effective rate of reimbursement, on a weighted average basis is only 137%. The fact is, the average rates place too much importance, in this case, on CPT code G6016 since it has such a high payer rate relative to its Medicare Rate. The outcome, in cases like this, would be skewed against you in a payer contracts' negotiation. It is not that the payer is "wrong" for telling you that the average reimbursement, below, is 178.5%. Rather, it is wrong for you to base your negotiation on this rate. You should, instead, be working with the weighted average of 137% and working your way up from there. It will happen, more often than not, that your average reimbursement will be higher than your weighted average reimbursement. The key reason is that there are very skilled actuaries that put these fee schedules in place and to level the playing field, you should do thoughtful analysis of your payer fee schedules using the weighted average fee schedule techniques discuss here. Payers often will quote higher averages across a total fee schedule of hundreds of codes while only a small number of codes, perhaps 15-40, or less, will account for the lion's share of your revenue.

Figure 1

A	B	C	D	E	F	G	H
CPT	**Volume**	**Payer $ Rate**	**Payer Revenue (Col C * Col B)**	**Medicare $ Rate**	**Medicare Revenue (Col E * Col B)**	**Average (Column C / Column E)**	**Wt. Average by CPT (∑ Column D)/(∑ Column F)**
99213	3000	100	$300,000	110	$330,000	91%	N/A, same as AVG
G6016	200	1600	$320,000	600	$120,000	266%	N/A, same as AVG
AGGREGATE	3200		$620,000		$450,000	**178.5%**	**137%** (∑ of Col D/∑ of Col F)

As the old saying goes, beauty is in the eyes of the beholder. Focus on weighted averages when valuing and negotiating your fee schedules.

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