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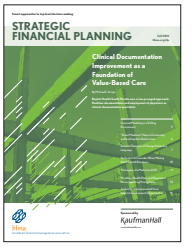

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Essential Elements of Charge Protection Language

By Laura Jacobson

Health plan contracts include charge limit provisions to ensure chargemaster increases above a predetermined amount will not lead to higher payments than were negotiated.

The chargemaster, or CDM (charge description master), is an integral component of hospital financial strategy, reimbursement, and the revenue cycle. Throughout the year, this "menu" of hospital service prices changes to reflect minor adjustments. Larger modifications are typically implemented at least once a year to maintain policy changes and stay competitive in a changing healthcare market.

While raising prices can appear to lead to higher payments from managed care payers, charge increase limitations are negotiated to prevent sizable payment increases. Key components of charge protection language include the different methods and applications of the provisions and the significant impact these can have on net revenue. In this article, we explore these components and take a look at what is seen nationally.

Charge Neutralization

The basic purpose of limit provisions is charge neutralization. Contracts include this provision to ensure chargemaster increases above a predetermined amount will not lead to higher payment than negotiated with the facility. Limits can range from a fully restrictive 0 percent upward

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and can even be included to neutralize a charge increase when the hospital plans for a decrease. In the latter case, the hospital may have informed the health plan of the intention to decrease charges. If the hospital does not decrease charges by at least the contracted amount, the health plan will neutralize the effect to payment by decreasing the percent of charge payment rates. When restricted to a 0 percent overall limit, percent of charge rates will be decreased when charges are increased by any amount, resulting in no payment increase for the contract. In addition to altering the percent of charge paid items, protection provisions can cause adjustments to inpatient stop-loss thresholds as seen in the examples below.

The basic terms of a contract are shown in the exhibit below. Example 1 shows a typical positive limit. The contract includes a charge increase limit of 5 percent, and the hospital reported a 7 percent overall increase to the health plan. Because the hospital exceeded the 5 percent limit, its inpatient stop-loss and outpatient rates will be adjusted. The inpatient per diems will not be affected. An adjustment factor will be calculated using the following formula.

(1 + allowed increase) / (1 + actual increase)

The stop-loss threshold is divided by the adjustment factor calculated below. Percent of charge items are multiplied by this adjustment factor.

(1 + 0.05) / (1 + 0.07) = 0.981308

The adjustment brings the stop-loss threshold to $50,952. Stop-loss payment is decreased to 49 percent of charges, and outpatient rates are decreased to 79 percent.

Example 2 in the exhibit below shows a contract that has the same original rates as example 1, but with a negative limit. The health plan and hospital have agreed charges will be decreased by at least 2percent but have implemented a 7 percent overall increase. This increase would have a significant effect on the health plan's terms. The adjustment factor is calculated using the same formula as above.

[(1 + (–0.02)] / (1 + 0.07) = 0.915888

This increases the stop-loss threshold to $54,592 and decreases stop-loss payment to 46 percent. Outpatient rates are decreased from 80 percent to 73 percent.

For a large health plan, the outpatient drop from 80 percent to 73 percent could cause a drastic decrease in overall payment. Though rare, as many facilities begin to decrease charges to stay competitive with freestanding facilities, this language may become more commonplace. Be aware of the potential reduction to payment that may be experienced with a negative limit. Negative limit language should be negotiated with a clear understanding of planned charge adjustments and renegotiated when necessary to avoid potential future losses if charge strategies change.

The degree to which protection provisions are restrictive is determined by more than the limit itself. Some contracts may include language indicating a guaranteed percentage *increase* to reimbursement. Cleverley & Associates refers to this as indexing.

This is shown in our last example in the exhibit below. If the hospital increased its overall charges by only 3 percent, an adjustment would be made to the rates based on the same formula to ensure the hospital experiences a 5 percent increase to reimbursement:

(1 + 0.05) / (1 + 0.03) = 1.019417

Following the same method of applying the adjustment as the other examples, the stop-loss threshold is decreased to $49,048. The stop-loss payment is increased to 51 percent of charges, and the outpatient rate is increased to 82 percent.

Impact of Varying Charge Increase Limits

Inpatient Terms	Example 1: 5% Limit	Example 1: Impact	Example 2: -2% Limit	Example 2: Impact	Example 3: Indexed Limit	Example 3: Impact
Payment	Per diems	No change	Per diems	No change	Per diems	No change
Stop-loss threshold	$50,000	$50,952	$50,000	$54,592	$50,000	$49,048
First dollar stop-loss payment	50%	49%	50%	46%	50%	51%
Outpatient terms						
Payment	80%	79%	80%	73%	80%	82%
Charge protection						
Charge increase limit	5%		-2%		5%	
Reported increase	7%		7%		3%	

Source: Cleverley & Associates, Worthington, Ohio. Used with permission.

Average U.S. Charge Increase Limits by Region	
Region	**Average Limit**
All U.S.	4.62%
Midwest	4.17%
Northeast	5.14%
South	4.93%
West	4.41%

Source: Cleverley & Associates, Worthington, Ohio. Used with permission.

This strategy may become more prevalent as hospitals try to decrease charges, but maintain current payment levels.

Limit Determination

In addition to understanding how limits work, knowing what the limit is plays a significant role in determining the impact. Two basic approaches are used to determine the limit. The contract may include a defined percentage, or it may refer to a published or indexed amount—typically the consumer price index (CPI). According to the Bureau of Labor Statistics (BLS), the CPI is the "data on changes in the prices paid by urban consumers for a representative basket of goods and services." Some contracts will include language referring to the CPI; however, the component used is not always specified. Below are three typical CPI categories for the December 2015 12-month change using BLS website data.

December 2015 12-Month CPI	
Consumer Price Index (CPI) Category	**CPI**
All services	0.70%
Medical care	2.60%
Hospital and related services	4%

Source: Bureau of Labor Statistics

Such dramatic differences between the categories illustrate the importance for hospitals to understand what will be used by the payer as well as how restrictive the limit will be for the facility.

Hospitals may also take interest in the average limits used across the country. The overall U.S., Midwest, Northeast, South, and West regions average limits were developed using proprietary data and regional parameters defined by the BLS.

The averages across regions are fairly close to one another (see first exhibit to the left), with the Northeast and South edging slightly above the rest. Though limits are approximately 5 percent, this does not mean every facility should negotiate a 5 percent limit. Hospitals should approach increase limit contract negotiations with an understanding of future financial strategies and individual net revenue impact.

Charge Reporting Methods

One of the key components of charge protection language is understanding how health plans determine if charges have exceeded limits. Health plans may review charge adjustments in multiple ways. Some of the most common are as follows.

- Overall chargemaster change
- Overall change to the health plan's patient mix
- Overall change reported separately for inpatient and outpatient services
- Overall change reported for services paid a percent of charge

The distinction between the methods is important. Each method may lead to results for services for a particular health plan, or a subset of services, that vary significantly from the overall change to the chargemaster.

Because individual health plans may use different methods of reviewing charges, it is crucial for hospitals to understand the specific expectations of each when reporting changes. The exhibit on page 4 shows the distribution of the two major charge reporting methods.

The Midwest, Northeast, and Southern regions mostly report charges based on the overall change to the chargemaster. The Western region is more evenly split between reporting based on the overall chargemaster change and changes to the health plan's book of business and other methods (i.e., inpatient and outpatient reported separately or percent of charge items only).

In a recent case example, a hospital was unclear whether the health plan evaluated the impact to the health plan's overall patient mix or if it evaluated the impact only to percent of charge paid items. When evaluating the impact for each, the two methods resulted in a difference of several hundred thousand dollars in net revenue, illustrating the importance of understanding the method used by each health plan.

Other than the net revenue impact, another consideration is the potential for charge audits. If an audit has determined a hospital has erroneously reported charge changes, the hospital may be expected to repay the amount in excess of the agreed upon percent. Most likely, the health plan can only audit charges reported for its patient mix. If the contract states the health plan determines the adjustment based on the overall change to the chargemaster, it may be beneficial to understand how an accurate audit can be performed. If the audit is truly only looking at the health plan's patient mix, the reporting to the health plan as well as the contract language may need to be adjusted to accurately reflect the health plan's method of evaluating adjustments.

Another crucial component when ensuring accurate reporting involves contract language specifying exclusions. Typically, exclusions include charges associated with drugs, prosthetics, and implants. Hospitals should understand exactly how these services are identified by health plans, so they can be excluded accurately from determinations of the charge changes.

Finally, hospitals should take into consideration whether multiple major price adjustments will be implemented within one year. They should determine whether charges have exceeded the limits for contracts that include charge protection language after the first increase. Failing to do so may understate the effects of the additional price increases on reimbursements.

Charge Reporting Method Distribution by U.S. Region					
Charge Reporting Method	**All U.S.**	**Midwest**	**Northeast**	**South**	**West**
Health plan's patient mix	11%	8%	0%	4%	28%
Overall chargemaster	73%	76%	85%	79%	57%
Other	16%	16%	15%	17%	15%

Source: Cleverley & Associates, Worthington, Ohio. Used with permission.

Final Thoughts

Multiple departments, including managed care, chargemaster, and finance, should work together to align financial strategies with knowledge of how managed care contract language plays into the bottom line. Based on the complexity, it is critical for hospitals to understand how limits are determined, as well as how health plans are evaluating reported charge adjustments. Understanding these components can help hospitals evaluate net revenue impacts that are the result of charge adjustments while remaining in line with financial goals. //

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