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How to use contract testing and analysis to prepare for payment changes

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Two areas that effect the impact of contract changes include how payers define categories and services and hierarchies of payment.

A substantial provider-payer contract is nearing the renewal period. The payer initiates proposed changes to current payment terms, but the provider already has in mind specific outcomes desired for the upcoming contract year. The provider is faced with two choices; accept and move forward with the proposed changes or engage in the negotiation process. What should the provider choose?

To make an educated next step, it is critical to gain specific information. Whether the contract is new or up for renewal, a thorough understanding of the financial implications of changes to provider-payment terms is vital for continued operations. Critical steps in the process include identifying the sources for contract testing, the approaches to analysis and the payment impacts.

Payer proposes payment terms

One approach involves testing the terms and methodology proposed by the payer. Through analysis, the provider can determine if the offered terms result in alignment

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Why initiate contract testing?

Contract testing may originate from a variety of sources.

Termination of contract. A provider could be faced with the termination of a contract and those patients could potentially leave the provider's payer mix entirely. Or the contract moving out of network creates a shift of patient volume, for example a large employer group, to another payer contract with different payment terms. What will either adjustment mean to the provider's net revenue?

Changes in legislation. Another foundation for contract testing involves the complications associated with changes in legislation. An example of this can be payment terms adjusting to include a provision to cap contracted payment at federal program methodology, such as the Inpatient Prospective Payment System or Outpatient Prospective Payment System. Providers also ought to be equipped with payment analysis for an adoption or variation of the "Medicare for All" initiative. Can the organization survive under this movement?

Modification to current terms. Most commonly, the source for initiating contract testing and analysis starts from the payer or provider desiring to alter current payment terms. If either party wishes to modify the terms, the relationship has now entered into a level of contract negotiations.

By using skilled resources to test changes, the provider increases the ability to validate any analysis estimated by the payer and develop counter scenarios to meet favorable objectives.

Bottom line, regardless of the cause, providers should ultimately want to prepare for the impact of payment changes. To accomplish full preparation or create a desired outcome, the various approaches to contract testing must be considered.

with the organization's financial goals. This approach seems simple enough, but the following elements must be kept in mind.

Definitions. How the payer defines payer categories and services represents the first key consideration. The definition of each service must be communicated to the provider, so payer and provider are on the same page. For example, does the payer use a specific set of revenue codes, HCPCS codes or a combination to define an emergency visit? Confirming detailed definitions will ensure each service is identified accurately in the tests.

Hierarchy of payment. The service category deemed primary, secondary and so on is another significant consideration. Hierarchy of payment involves determining how the payer pays a claim when multiple services are present. For example, the claim represents a patient presenting in the emergency department, followed by a surgical service in the OR and concluding with the patient being placed under observation. In this scenario, how will the payer apply payment if the contract includes payment categories in all three of these areas? Results could be significantly different if surgery groups are applied in the test, but the payer interprets that observation takes precedence in the hierarchy.

Payment methodology. How the rate is applied is another consideration when testing proposed terms. For example, is the payer paying a service at a case-rate level, at the unit level or once per day? Application of a per unit methodology can produce vastly different results than once-per-day payment methodology.

If testing a proposal provided by the payer, the next step will be to apply the current contract terms to a set of claims. This will determine the base or benchmark payment. Next, apply the proposed terms to the same set of claims. Using the same set of claims in the base and test is critical to provide an apples-to-apples comparison of terms. From here, the impact of moving to the new terms proposed by the payer can be determined.

Provider desires specific outcome

Another approach to contract testing is more complex. The provider may have an idea of a desired outcome (e.g., an overall increase of 5% for the payer over the previous year). In this situation, the provider may want to determine the optimal contract terms to help reach this goal and then present the terms to the payer. While the elements in the first approach are applicable here as well, additional key elements should be kept in mind for this approach.

Leverage. The first element is determining how much leverage the provider has with the payer. In some cases, the size of the hospital and payer may determine the negotiation ability of the provider. Knowing this up front can save time during the testing process.

Extent of changes. Another aspect is determining how much of the original contract the provider wants to change and the payer is willing to change. Any combination of changing the rates or the methodology and structure can be involved. It is important to know what parts and to what extent they can be tested as certain terms may already be deemed non-negotiable in the contract.

Establishing the base or benchmark payment is still needed under this approach. The testing phase of various terms based on the provider desiring a specific outcome may take longer, depending on the goals, as well as the elements, changing in the tests. Consider the following example.

A provider's current contract includes a mix of fixed rates (e.g., per diems, case rates) and percent of billed charge payment. The goal is to increase overall payment for this contract by 5%. Constraints include limited flexibility to adjust only the fixed rates, and methodology must be kept the same.

The provider must now determine the level of increase to the fixed rates necessary to achieve an overall 5% increase. A complication arises due to an inpatient stop-loss provision and a lesser of provision applied to inpatient and outpatient claims. Increasing the fixed rates will not

What to test and how to test it?

Depending on the goals for finalized payment terms, the provider may approach the contract testing process in two general ways.

Payer proposes payment terms. This approach involves testing the terms and methodology proposed by the payer. Through analysis, the provider can determine if the offered terms result in alignment with the organization's financial goals.

Provider desires specific outcome. This approach to contract testing is more complex than the payer proposal of payment terms. For example, a provider may have an idea of a desired outcome (e.g., an overall increase of 5% for the payer over the previous year). In this case, the provider determines the optimal contract terms to help reach this goal and then presents the terms to the payer.

Either approach could be enhanced by attaining payment-term intelligence involving benchmark data. Utilizing existing comparison data for payer-specific payment levels along with either of the methods creates powerful information to assist with the testing and analysis process. Regardless, with either approach, specific element details are crucial to understand prior to initiating testing.

only increase payment for some claims but will also cause movement in and out of stop-loss and lesser of claim status, making the overall payment more unpredictable.

With charge sensitivity involved, any future price increases to the chargemaster must be incorporated as well. Comparisons to the benchmark payment for each test will help determine the new rates that help reach the 5% increase goal.

For either approach, a key challenge associated with contract testing is utilizing a comparable base of claims data. The data criteria used by the payer to estimate impact is often a pitfall when comparing results as different claim date ranges may have been used for the analysis. A critical aspect of accurate testing is using the same criteria as the payer to define the data set involved, including covering seasonality.

Once the proposed rate impact or new rates are formulated, it is time to communicate the results to the payer.

Communication of testing outcomes

After initial testing is complete, results of the contract changes should be available for quick identification of impact. A report providing the impact is a useful way to communicate the results. Depending on the desired level of change the parties want to review, layout of the results can be displayed in a few ways. Several types of suggested views of results include:

- Overall impact
- Patient type impact (inpatient/outpatient)
- MS-DRG impact
- Service impact

Impact reports compliment the negotiation process by providing a tool to use with the payer to discuss outcomes and potential further testing. This is especially true when testing proposed rates provided by the payer. If the results are not at the level anticipated by the provider, presenting impact reports to the payer may aid in further negotiations until both parties are satisfied.

When developing contract terms to meet a desired goal, the provider also needs to communicate the new rates to the payer. Depending on what the payer requires, this can be accomplished by a summary letter or report of new terms presented with the impact reports. Including as much detail as possible about any changes made in the test ensures both parties are on the same page.

In addition to displaying the testing approach results, once again, benchmark data for payer-specific payment levels can significantly enrich the communication.

Next steps

Results are in, and now the provider needs to determine if additional testing is needed or if both parties are prepared to proceed. With the results information gathered and benchmark data for payer-specific payment levels in hand, providers may decide to continue strategizing other scenarios along with understanding the impact of each. Or the provider may determine the best options are already available. By executing the knowledge gained through this process, providers are equipped to arrive at the table knowing minimal, target and optimal payment-term goals. In addition, this process may bring to light any elements of the payment terms requiring additional attention and resolution with the payer. After new terms are accepted by both parties, the provider must now prepare for the upcoming effects of executing the payment changes.

Mutual understanding

Once the provider and payer gain a mutual understanding of the goals and process of contract testing, both parties can move forward with more confidence. Arming themselves with the proper tools and knowledge to accomplish financial goals can ensure a smoother negotiation process and transition to new contract terms.

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