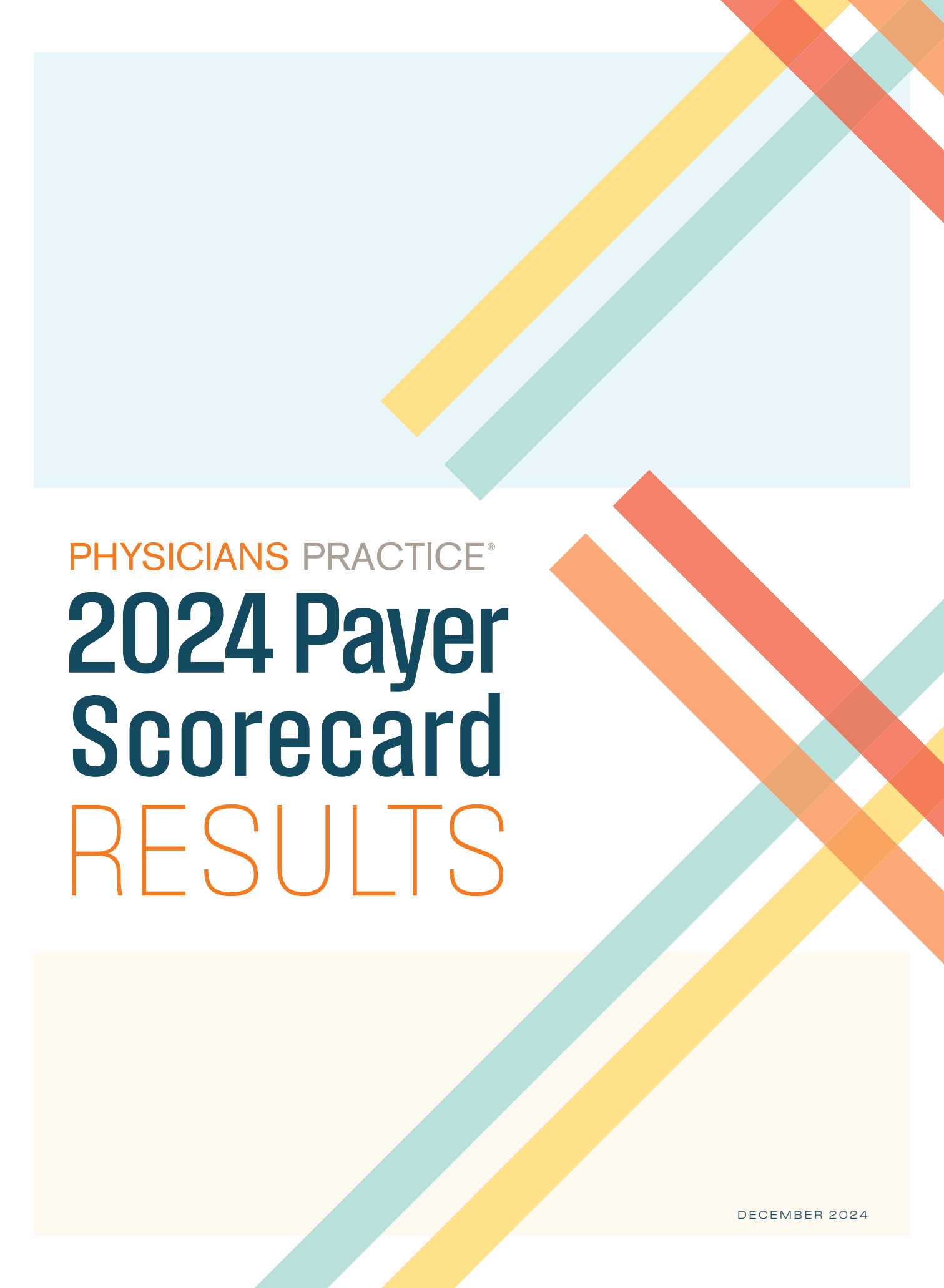




PHYSICIANS PRACTICE[®]

2024 Payer Scorecard RESULTS

DECEMBER 2024

PHYSICIANS PRACTICE®

2024 Payer Scorecard RESULTS

By Keith A. Reynolds, Editor

The verdict is in for how practices feel about their payers - and it isn't good.

The relationship between medical practices and the insurance companies they work with is one of the most fraught in the entirety of the health care industry.

To better understand this [dynamic](#), Physicians Practice developed a Payer Scorecard that asked respondents to rate [the payers](#) they deal with on criteria including practice communication and customer service.

Here are the results:

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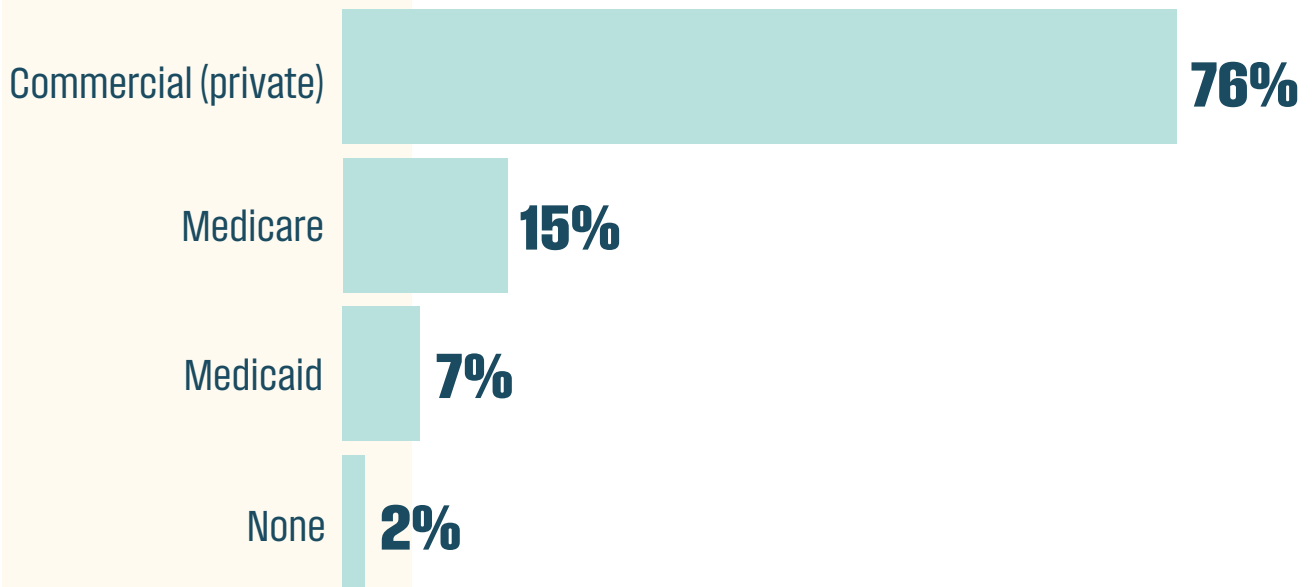
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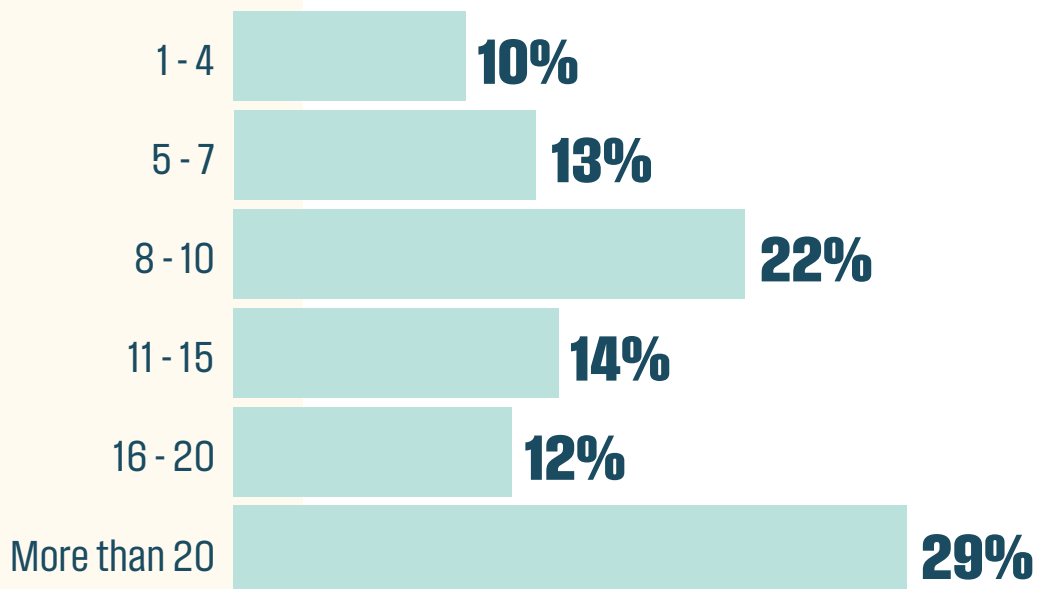
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Mike Hennessy Sr., 1960-2021

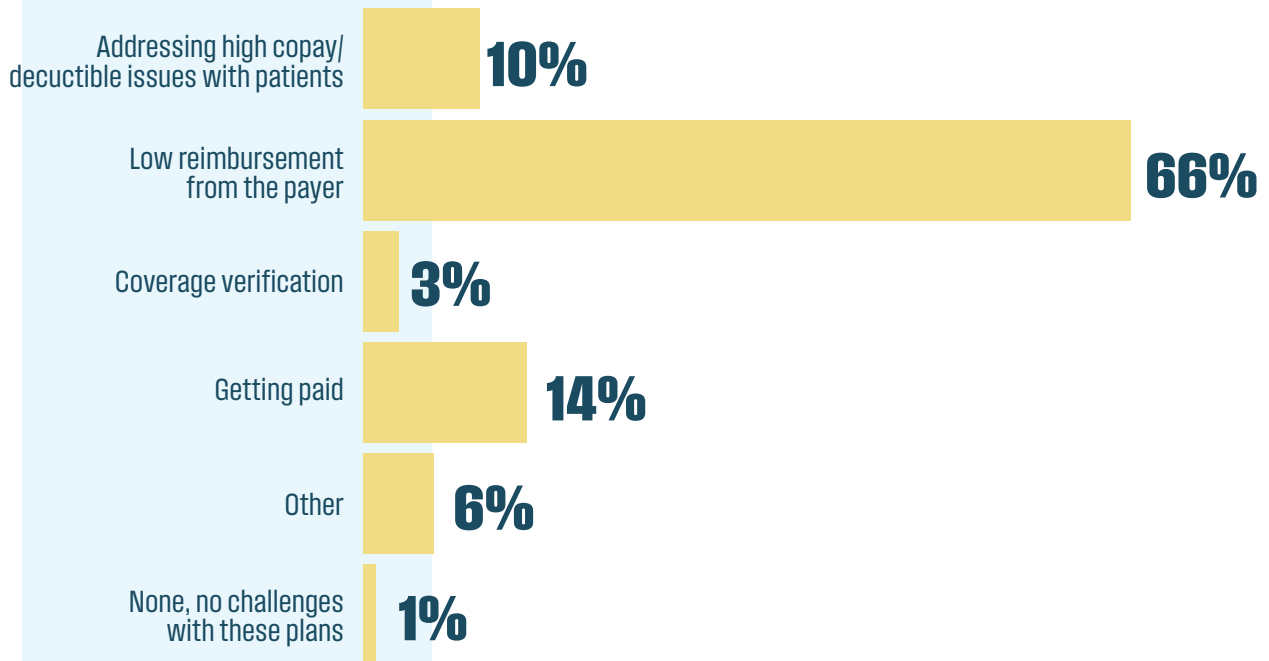
Which payers do your practice accept?



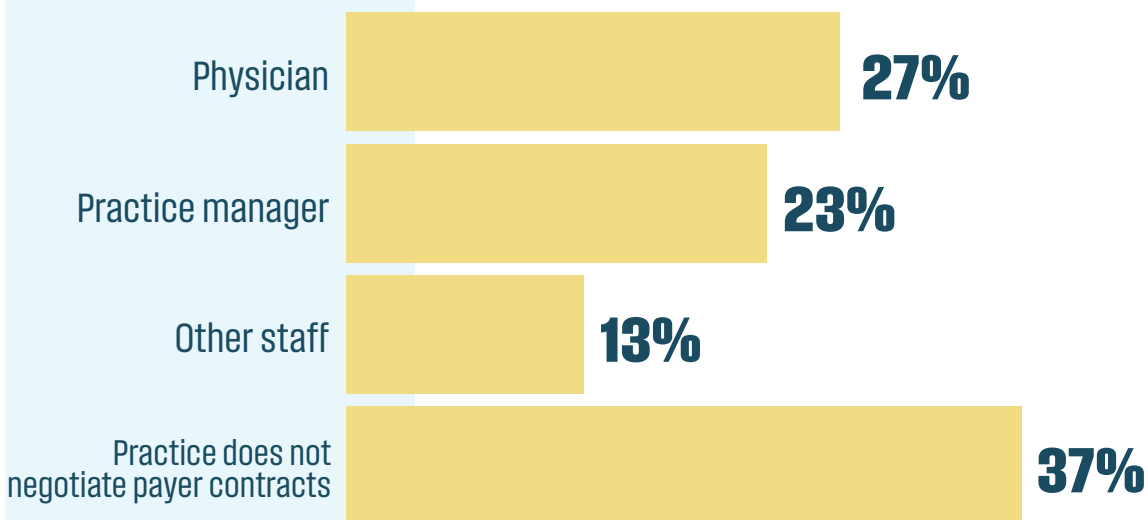
How many payers does your practice accept?



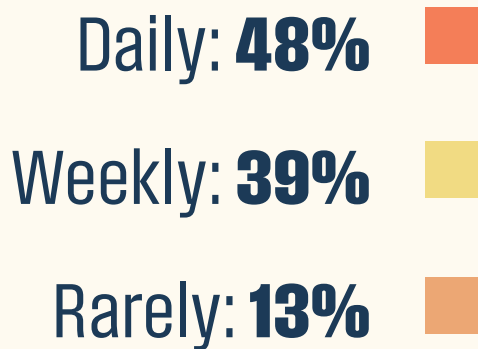
What are the biggest challenges with your biggest payer's plans?



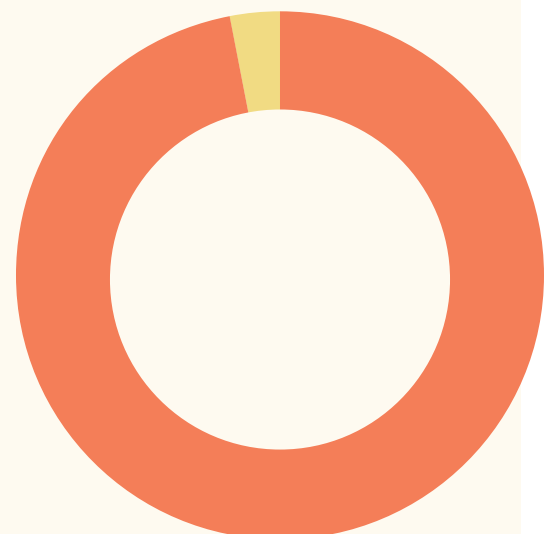
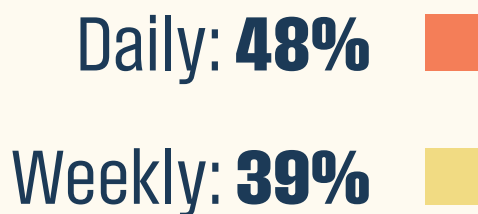
Who at your practice negotiates payer contracts?



How would you characterize your prior authorization experience in the last year?



Do you think there should be a CPT code requiring payers to reimburse for prior authorization work?



1 = poor; 5 = excellent

Overall Payer Score



2.02 out of 5

Patient Information

How would you rate your largest payer on patient information topics, such as the clarity of the info on the patient's insurance card, responsiveness to changes in patient data provided by your practice, the prior authorization process, and communication with patients on copays/deductibles?

2.25 out of 5



Practice Communication

How would you rate your largest payer on practice communication, including clarity on who practice should contact with inquiries, notification of contract changes and formulary updates, ease of navigating their website/portal and phone systems?

2.03 out of 5



Payments/Reimbursement

How would you rate your largest payer on payment and reimbursement issues, including turnaround time, reimbursement rates matching what's specified in contract, claim success, fair/reasonable rate compared to other payers, and explanation and ease of appeal process for denied claims?

1.96 out of 5



Customer Service

How would you rate your largest payer on customer service topics, including response time to inquiries, time on hold when contacting customer service, willingness to negotiate on reimbursement rates and timeliness to respond to questions and/or issues?

1.84 out of 5



What is your biggest challenge with your biggest payer?

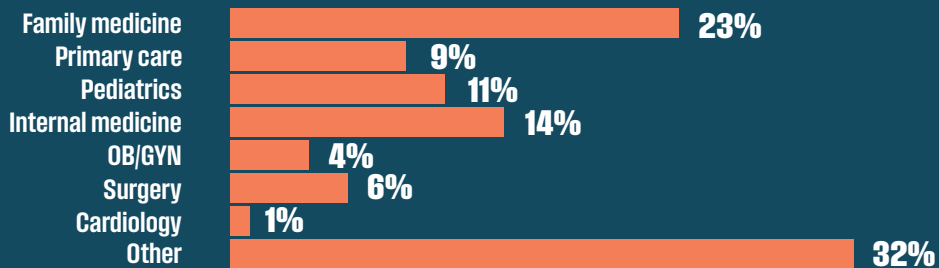
- Their current systems don't interact well with our billing systems, requiring office staff to correct claims leading to delayed payments.
- Reimbursement stinks. I quit !!!!!
- Staff at the insurance companies contracted are mostly out of the country and do not know the issues we have and do not like to refer the questions or specific issues to any expert in the field.
- My small practice is ignored. They would not negotiate fees. For more than 15 years, there has been no increase in fees, only a steady decrease. It is a shame; [it seems they have] no respect any longer for providers.
- Prior authorizations waste so much time for what should be a simple process.
- A lack of urgency or even motivation to provide basic services

How can payers improve their relationship with practices?

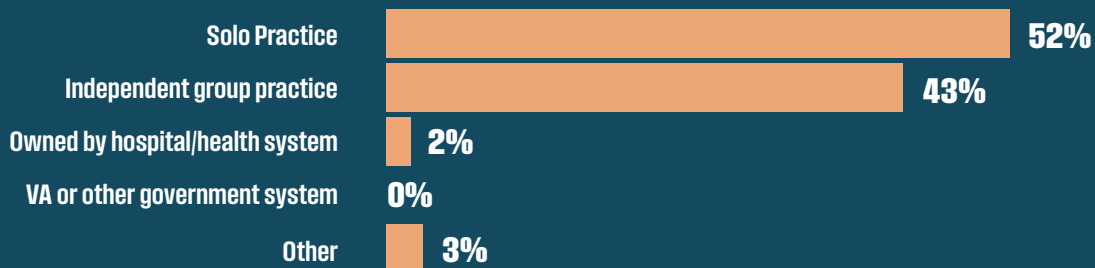
- Streamline systems to allow for clean claims the first time.
- Have a dedicated provider relations contact so we know who to talk to, and who to call to get responses to critical questions, [so we do] not have to send emails to faceless representatives that have a low rate of resolution.
- Communicate. Show WHY they deny, and what EXACTLY can be done to help the patients who pay them. Do not simply deny with NO guidance.
- Pay us enough to survive. Instead, they raise hospital payments. Pay us more so we could hire more doctors and physicians assistants and keep people OUT of those hospitals.
- Stop putting technology problems and carrier losses on the provider and their patients.
- Instead of looking at me as an expense, look at me as a tool to care for their beneficiaries.
- Stop requiring prior authorizations for generic medications and obviously necessary medications.

SURVEY DEMOGRAPHICS

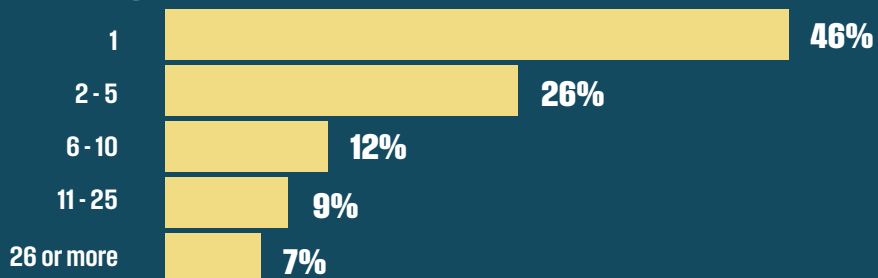
What is your practice's specialty?



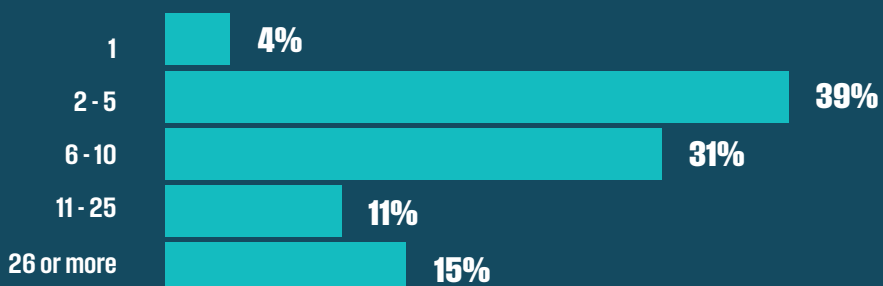
What type of practice do you operate?



Number of physicians at practice?



Number of support staff at practice?



Reining in Administrative Burden

By **Meade Monger**

Addressing the problem requires a multipronged approach

Doctors and medical practices are mired in administrative tasks. One of every five dollars of U.S. gross domestic product, or \$4 trillion, is [spent on the health care industry](#). And a quarter of that is spent on administration, with half of the \$1 trillion devoted to complex billing processes. It's not only back-office workers who are sucked into the whirlwind of medical administration. Doctors spend up to 20 hours a week on [paperwork](#), often taking as much time to document patient visits as they do actually caring for patients.

The burden of health care administration has put doctors and small medical groups at a disadvantage compared with larger players and insurance companies. The situation is so bad that doctors are [leaving the profession](#), and otherwise healthy small practices are deciding they have no choice but to be swallowed up by larger medical groups or to shut down.

But there are solutions. Doctors and other health care professionals need to know the following:

- Detailed prices are finally starting to become publicly available. Although you almost need to be a data scientist to figure out those prices, providers can now use some benchmarks to negotiate prices with payers.
- It may be hard to believe, but many providers don't know the floor price of procedures. It's hard to run a practice without this information.
- The reasons for [payment denials are important](#) so fixes can be made at the front end of the payment process to avoid them and thereby reduce administrative work.
- Process automation, including the use of [artificial intelligence](#), increases efficiencies and performs tasks at a small fraction of the time and costs now devoted to them.
- Transitioning to value-based care can save time and lead to better care.

For health care providers, the headache tends to involve three interlocking problems. The first is what I call a wild west approach to pricing baked into America's fee-for-service payment model. That's where the cost of a procedure can vary widely.

When a regulation recently took effect mandating that hospitals disclose their standard charges, the variations were stunning, and the presence of big government payers such as Medicare only makes the situation more unstable. There are, for example, hundreds of procedures for which commercial payers' prices are [tens or even hundreds of times more](#) than what Medicare reimburses.

Pricing remains so opaque and complex that most providers are forced to offer the bulk of their services without knowing in advance

what they will be paid, contrary to traditional business models. This leaves aside the penalty that smaller providers face because of their limited ability to bargain with large payers.

The second problem for providers is just making sure they get paid. Four years ago, about 9% of reimbursement requests by providers were [denied by payers](#). Today that number is closer to 12%, resulting in a hit of more than \$100,000 to a practice with \$1 million in billings.

But that tells only part of the story, because the 12% of billings ultimately written off by providers is less than half the initial rate of such denials, meaning untold hours spent trying to limit losses.

Third, growth in process automation may be leading to an even greater power imbalance in the administrative relationship between payers and providers. Well-resourced payers have begun to use artificial intelligence to find ways to deny bills submitted by providers.

While process automation can help providers keep up with payers, what they often really need is better data about their own operations. Many find it difficult to understand the cost of the care they are providing.

For example, knowing what it really costs to provide a hip replacement is crucial for numerous reasons. For one thing, it makes productive rate negotiations with payers possible. How can a doctor agree to perform hip replacements if the reimbursement being offered by a payer is below the cost of providing the service?

Conversely, if a practice discovers it is efficient at performing hip replacements, it may choose to focus on performing them and negotiating higher prices for them than for similar procedures. Meanwhile, efficiently capturing all the different contractual rates in place with payers into a common dataset can make tools such as accounts receivable reports more meaningful.

Over time, the American health care system may move from fee-for-service toward [value-based care](#), in which providers are paid fixed rates to care for patients. Doctors would have the freedom to use that money for care as they see fit.

But while such an evolution might help with our trillion-dollar administrative bills, it could also force providers to shoulder even more risk, further pushing smaller practices to seek refuge in larger, more bureaucratic groups. That's because doctors would have to pay for cost overruns.

The best-case scenario would be if providers addressed the administrative problem now rather than taking on a much bigger task that would further add stress. This can be done with automation, which also helps better position providers for transitioning to value-based care.

Meade Monger is founder of [CenturyGoal](#), a health care consultancy.