Health Directions

Business solutions for healthcare organizations

How to Survive the Coming High Deductible Environment

Daniel J. Marino, President

Agenda

- Growth of Consumer-Driven Health Care
- Understanding HSAs, HRAs, and FSAs within HDHPs
- Collection strategies under Adjudicated CDH Payment Structures
- Front-end Collection Techniques
- Monitoring Tools and Indicators
- Payment Analysis and Managed Care
- Case Studies

Health Directions, LLC

- Health Directions is the premier provider of Consulting Services to Academic Medical Centers, Physician Practices and Hospitals. We support our clients in achieving their optimal financial performance.
- Health Directions delivers its entire suite of Practice Solutions (financial turnaround, revenue cycle management, operations, strategic planning, compensation, EMR implementation and practice transition) through a Seasoned Team of health care professionals
- Health Directions has been assisting hospitals and physician improve their financial performance since 1985

Major Health Directions' Clients

Client	Location	Providers	Locations
Summit Medical Group	Summit, NJ	140	25
Holzer Clinic	Gallipolis, OH	120	15
Univ. of Texas- Physicians	Houston, TX	520	17
U. of Florida. Medical Group	Gainesville, FL	700	15
Kelsey-Seybold	Houston, TX	280	25
Advocate Medical Group	Des Plaines, IL	220	18

Successful Group Practice And MSO Trends

- Successful groups have structures in place to proactively measure and report on high-level financial indicators
- Contract management and evaluation is an integral part of overall performance
- Ability to anticipate changes in the market and modify operations
- Practice Administrators use business metrics to identify areas to focus efforts for process improvements
- Successful MSOs use comprehensive business metrics and dashboard reporting to support innovative management models and drive system wide performance

Health Care is Consumer-Driven

- The current trends show an increase shift across the industry for patients to take more responsibility for Healthcare spending
- Payers shifting financial responsibility to the patient
- Employers are shifting healthcare costs to employees
- Healthcare providers are seeing a shift in payer reimbursement to patient (self-pay)
- Government is promoting Consumer-Driven Healthcare as a means of slowing the growth of national healthcare spending

Consumer-Driven Healthcare Continues to Drive Changes

- Over the past few years, the healthcare industry is seeing a dramatic change in reimbursement flows
  - Consumers are given more control and responsibility over healthcare spending
  - Introduction of "non-traditional" third parties
  - Insurance products are designed to lower employer premiums
- Advent of High Deductible Health Plans (HDHPs)
- Adjudicated Consumer-Driven Healthcare Accounts
  - Health Savings Accounts (HSAs)
  - Health Reimbursement Accounts (HRAs)
  - Flexible Spending Accounts (FSAs)

HSAs Promoted by Congress as a Means to Lowering Costs

- The Medicare Modernization Act (MMA) of 2003
  - Created tax-free health savings accounts for people who choose high-deductible plans
  - Designed to help individuals save for qualified medical and retiree health expenses on a tax-advantage basis
- HSAs are a financial asset, similar to a 401(k) plan allowing pretax dollars to be put into savings accounts earmarked for qualified medical expenses
- Consumers, through the use of HSAs, pay the deductible amount associated with High Deductible Health Plans (HDHP)

Understanding High Deductible Health Plans

- Insurance payers developed products with high deductibles to offer employers an opportunity to lower insurance premiums
- According to the National Coalition of Health Care, employers face health insurance premiums that have increased by 73% since 2000
  - Average employee contribution increase 143% and out-of-pocket expense has increased over 115%
- Healthcare financial burden is shifted to patient
- Providers who do not have processes and workflows in place to collect deductibles can see reductions in cashflow and collection rates

Understanding HRA and FSA Accounts

- Health Reimbursement Arrangements (HRAs)
  - Personal account from which employees can pay directly for their medical care.
  - A June 2002 Internal Revenue Service (IRS) revenue ruling clarified that HRA funds can roll over each year and grow tax free.
  - The ruling puts HRA spending on an even playing field with third-party payments.
- Flexible Spending Accounts
  - Funds set assigned by employees on a pre-tax basis for the payment of health care expenses that third-party insurers do not pay
  - Have a use-it-or-lose-it provision
- All Consumer-Driven Healthcare Accounts allow for payment with a debit card

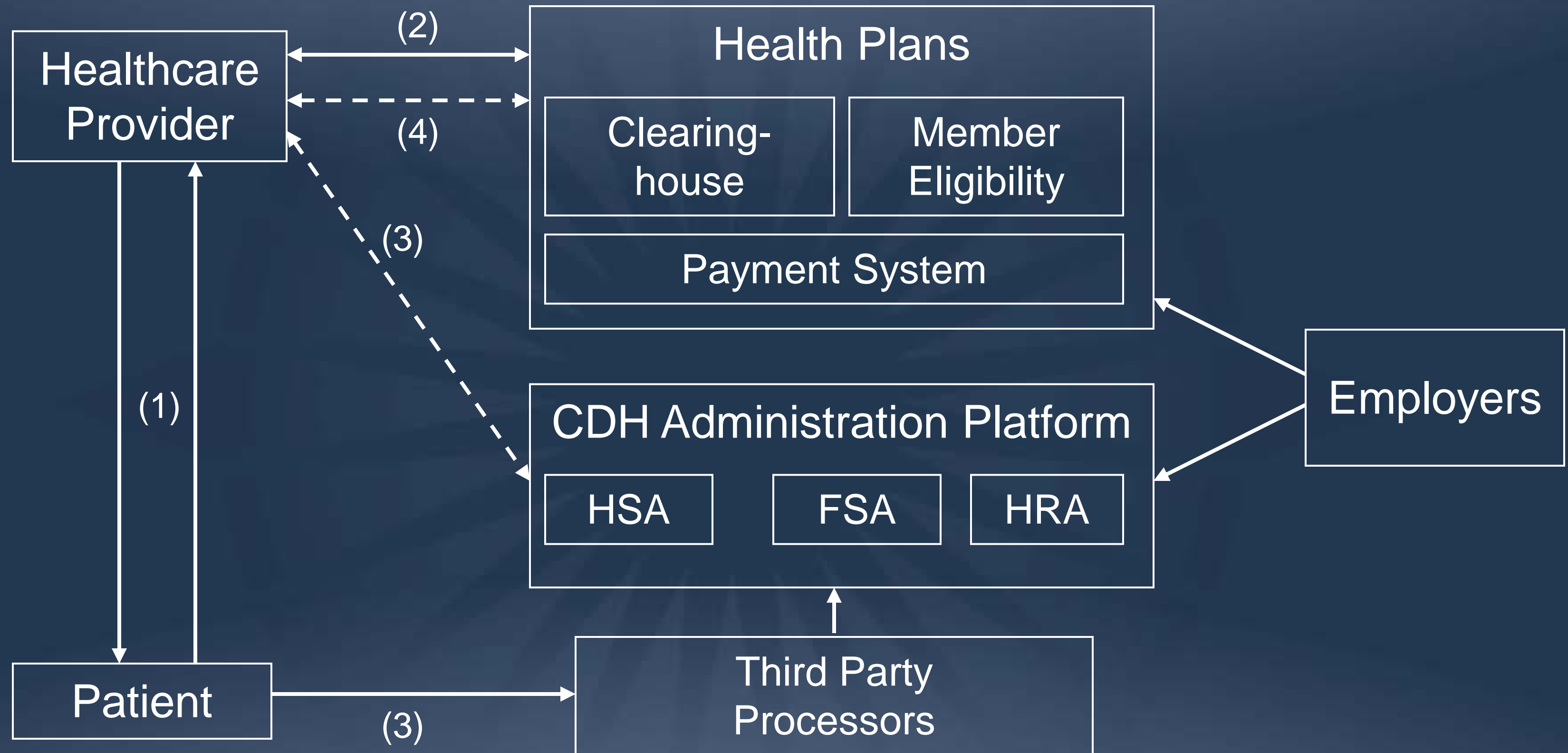
Impact of Healthcare Providers

- CDH markets are introducing “non-traditional” entities into the healthcare revenue cycle
  - Financial institutions, Third Party Payer (TPAs), etc.
- Greater emphasis on front-end, time-of-service collections
- Patient verification and benefit eligibility will continue drive revenue cycle performance

Challenge for Hospital-Based

- Obtain all the correct information form the hospital to bill the patients appropriately
- Can not always collect from the patient upfront
- Hospital based groups may not have the based relationships with hospital registration
- Incentives for hospitals and hospital based groups are not aligned

CDH Payment Flow: Patients Play a Larger Role



(1) Healthcare service and exchange of insurance information
(2) Benefit verification and eligibility
(3) Consumer directed payments
(4) Insurance coverage payments

Front Desk Procedures with HDHP

- Difficult for front desk personnel to identify HDHP patients
  - Most of the time, only PPO is stated on the card
- Need to incorporate patient verification procedures
  - Identify total plan deductible
  - Either % of deductible met or remaining deductible amount
- If not contracted with plan, financial counselors should negotiate with patient or plan, and try to collect 75% to 100% upfront
- If patients are identified with a participating HDHP, consider collecting 75% of estimated visit costs during check-out
- Communicate payment expectations with patient upon verification and again at check-in

Collection Procedures with HSAs

- 2 Models of HSAs
  - Integrated model: Health plan owns or partners with a bank
    - Banks administer almost 90% of HSAs
  - "Plug-and-play" model: A third partner administers the HSA providing access to health plans and providers
- Challenging for providers to know if patients have a HSA
- Should try to identify in practice management system if discovered during patient verification

New Philosophies in Pre-registration and Registration Processes

- Shift of revenue cycle activities upstream from business office to front-end/patient access functions
- Patient verification is the key to identifying HDHP patients
- Develop an upfront collection policy that is communicated with patients
- Receptionists need to be prepared to estimate a payment amount and communicate with patients
- Make use of financial counselors in communicating payment arrangements with patients

Case Study 1

Background

- 140 plus providers in multi-specialty group practice in small rural community
- Large amount of managed care contracts
- Largest employer in community adopted HDHP for their employees
- The employer encouraged FSAs for their employees
- The revenue cycle activities were weak, especially front-end collections

Practice's Financial Indicators

Annualized charges:	$180MM
Annualized collections:	$95MM
Gross Collection %:	54.9%
TOS Collection Rate:	28%
A/R per physician:	$353,000 (versus a target of $83,095)
Days in A/R	62

Overview of Revenue Cycle

- Minimal patient verification performed prior to patient visit
- Only collecting 25% of co-pays and small percentage of self-pay
- Rely on business office for verification and managing claim denials
- Self-pay collection team follow up on patient statements and outstanding accounts
- Bad debt write-off amount at over 7% annually

Impact on the Group From HDHP

- The group projected almost a 10% decrease in collections HDHP and a lack of front-end processes
- Concerned about the negative community impact as a result of any new collection procedures
- Receptions did not have the current skills required for front-end collections
- Did not know where to start

Process Changes and Staff Education

- Began with staff (primarily receptionist) education
  - Provided enhanced training on key insurance plans
  - Patient responsibilities associated with plans
- Introduced patient verification on all new patients and eventually, patients seen longer than 6 months
- Incorporated "collection" techniques into registrar positions
  - Scripts on how to ask patients for money
  - Communicating payment expectations
- Incorporated financial counselors within clinics
- Developed a formal check-in and check-out desk

Developed Front-end Tools

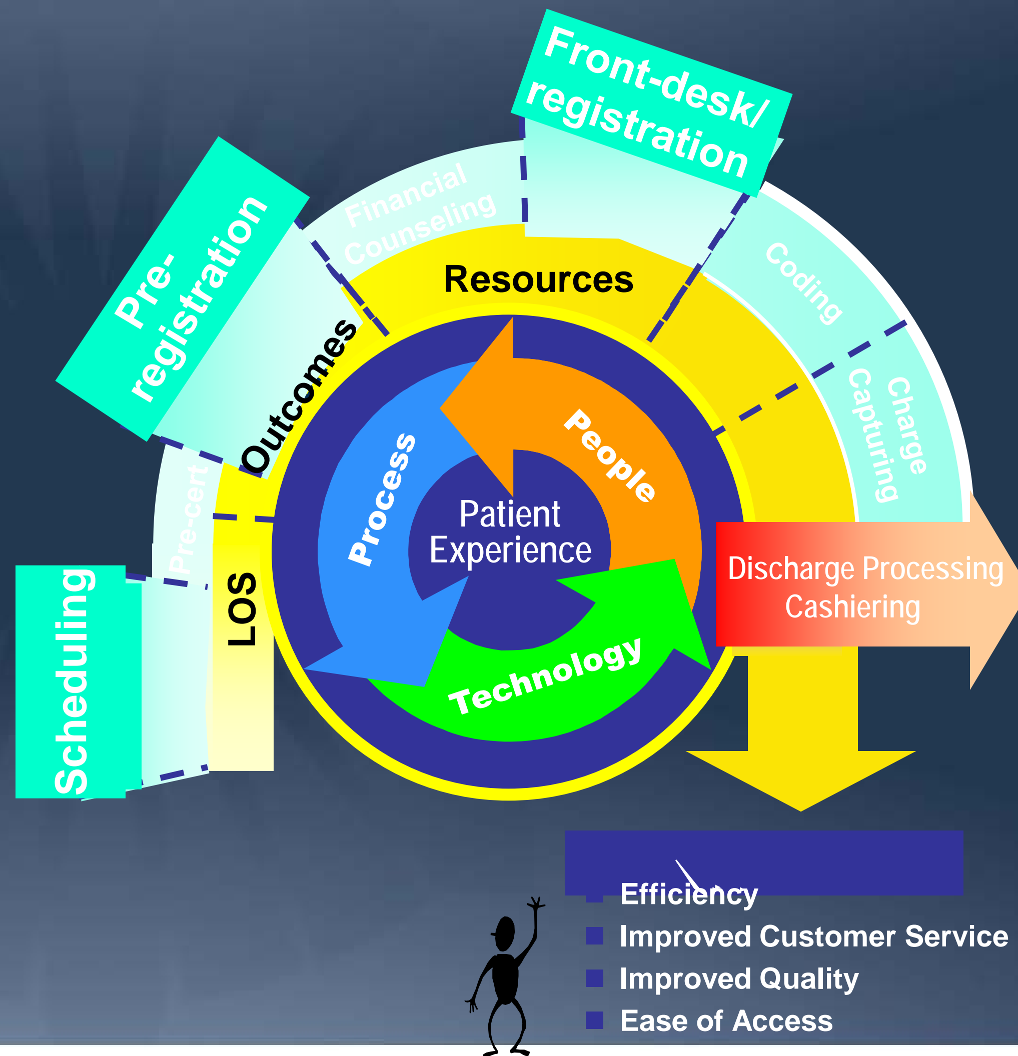
- Modified their practice management system to begin identifying patients with HDHPs and FSAs
- Worked with their clearinghouse and practice management system to incorporate electronic verification
- Assist receptionist and financial counselors to estimate charge for day's visit
- Instituted a patient call/appointment reminder system that communicated payment expectations
- Developed a policy to collect 75% of the estimated visit charge at TOS for all patient responsible payments

Results

- The transition and staff education took approximately 90 days to fully implement
- The overall gross collection rate increased to approximately 58%
  - Self pay collections increased to over 85% with 95% of copays collected at time-of-service
- Largest challenge was with capturing information during insurance verification
- Offered additional budget payment plan options to patients with HDHPs and FSAs

Critical Components of HDHPs

- Incorrect or ineffective registration and scheduling can account for 25% of claim edits and denials
- Insurance verification and pre-registration processes directly effect collections
- Estimated revenue lost due to incorrect registration is $50 to $350 per visit depending on specialty



Insurance Eligibility and Verification

- Becoming an increasingly important component in supporting the revenue cycle
- Groups who do no verify insurance or eligibility are at a significant disadvantage
  - No way to identify HDHP patients until after the visit
- Non-covered service, authorization required, or patient not enrolled could result in 3% to 8% of Group's total denial rate
- Incorporate tools already within Groups disposal
  - Clearinghouse
  - Electronic eligibility
  - Payer web sites

Front-end Collection Components

- Under most payer contracts, patients are responsible from 5 - 25% of total allowable remittance.
- Collecting patient responsible payments at time-of-service can reduce accounts receivable by over 15%.
- Review of payer's fee schedule of the top payers
- Incorporate fee schedules into information system.
- "Best" opportunity to collection patient's portion of visit.

The Earlier You Communicate; The More You Collect

- *Estimated Collection Percentage by Front-desk Function
  - Check-in 90%
  - Check-out 70%
  - On month after visit: <40%
- Prior to visit, healthcare is the greatest priority to patients
  - Psychological advantage for healthcare provider in collecting at check-in
  - Following the visit, healthcare drops to last priority and the “debt” becomes the high priority

*Results of a survey performed by Passport Health Communications

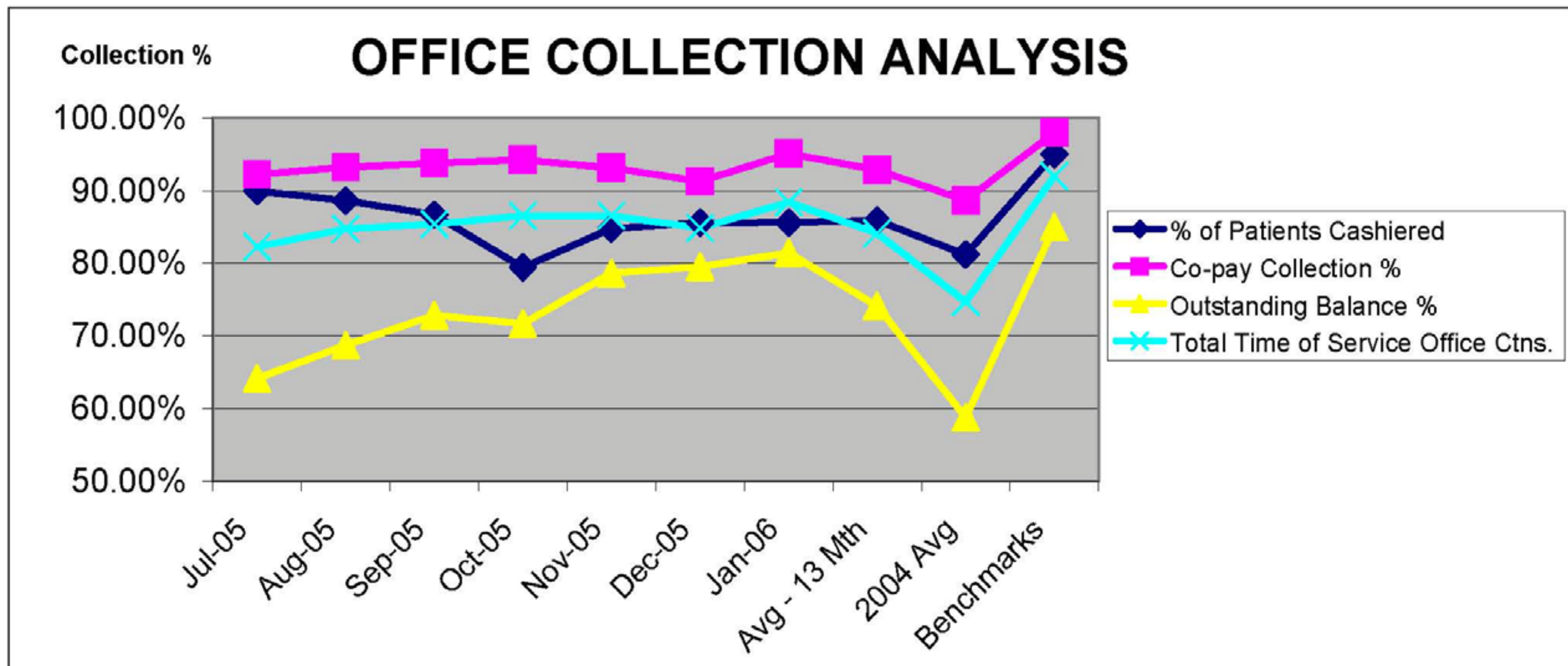
Tips on Improving Front-end Collections

- Help staff understand what to collect and how to ask
- The more comfortable your staff is on collecting, the greater your success
- Provider receptionist/financial counselors with the right tools
  - Fee schedule and estimated exam fees
  - Practice management system as a guide
  - Collection policies and protocols
- Deploy signage and “patient-friendly” collection campaign within the office
- Share the collection burden
- Build a strong relationship with the hospital

Front-end Performance Improvement Requires Measurement

- Financial indicators help define practice's priorities and evaluate progress
- Incorporate process improvement with collection outcomes to evaluate success
- Dashboard reports must be simple and understandable to physicians and staff:
  - Indicators should translate well into operational processes
  - Create and understanding of how indicators can be impacted
  - Measure the entire revenue cycle as well as it's components

Sample Office Collection Report



Collections Percentage

Indicator Category	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Jan-06	Avg - 13 Mth	2004 Avg	Benchmarks
% of Patients Cashiered	89.95%	88.61%	86.67%	79.42%	84.80%	85.56%	85.59%	85.89%	81.20%	95.00%
Co-pay Collection %	92.25%	93.23%	93.78%	94.23%	93.15%	91.27%	95.10%	92.87%	88.67%	98.00%
Outstanding Balance %	64.15%	68.73%	72.87%	71.67%	78.65%	79.54%	81.45%	74.12%	58.78%	85.00%
Total Time of Service Office Ctns.	82.27%	84.73%	85.39%	86.55%	86.55%	84.85%	88.40%	84.12%	74.71%	92.00%

Payment Analysis With HDHPs

- Most Common Problems
- Ineffective reimbursement analysis can cost 5-15% of net revenue
- Payer payment systems do not accurately reimbursement according to carve-outs or procedure exceptions
- Most practice management systems lack processes to verify expected payments
- Staff's lack of understanding of complex contacts
- Lack of reporting available to detect underpayment

Auditing Payer Contracts

- Organize contract files
  - Charges, allowable, reimbursement by provider and code
- Identify key indicators to monitor
  - Collected versus collectible
- Monitor monthly or quarterly
- Develop a contract issues database
- Be prepared to mediate, arbitrate or litigate

Collected Versus Collectable

Collected: Payment received and line item posted

Collectable: The allowable amount as negotiated in contract

2 CvC Indicators

90 Day CvC: (Allowable posted 4 months ago)/ (Payments received in the next 3 months)

90 Day CvC: 92-94%

Annual CvC: (Allowable posted 13 months ago)/ (Payments received in the next 12 months)

Annual CvC: 97-99%

Sample 90 Day CVC Report

SEPTEMBER, 2007 INSURANCE PLAN	CHARGES	ALLOWABLE	COLLECTED	(Coll./Allow.) % COLLECTED
AETNA	$1,639,044	$1,062,610	$1,043,451	98.20%
AMERIHEALTH	$185,361	$145,090	$140,925	97.13%
USHC	$1,986,460	$1,267,667	$1,210,398	95.48%
UNITED HLTHCARE	$1,653,396	$1,283,729	$1,219,456	94.99%
MEDICARE	$4,532,591	$1,799,580	$1,679,789	93.34%
CIGNA	$1,146,525	$911,439	$847,316	92.96%
OXFORD	$1,318,334	$1,053,521	$960,497	91.17%
HELATHNET	$579,508	$477,573	$418,675	87.67%
HORIZON	$258,003	$258,003	$195,264	75.68%
SELF	$272,173	$272,173	$188,777	69.36%
TOTAL	**$13,571,395**	**$8,531,385**	**$7,904,548**	**92.65%**

Payment Analysis

- Recommendation for Payer Auditing
- Identify underpayments, missing payments, incorrect rejected claims
- Educate staff on contracts and reimbursement
- Establish payment analysis trending reports (CvC, etc.)
- Identify clause in contract which allows for correct reimbursement
- Can add 5-10% of annual revenue to practice
- Need to be persistent
- Consider using an outside consulting group to assist with the analysis and negotiations

Managed Care Contracting

- Recommendations for improved negotiations
- Begin the payer’s financial analysis early
- Identify a list (or database) of contract issues
- Carefully analyze the payer contract language including HDHPs and don’t be afraid to ask for revisions
- Analyze changes to fee schedule and financial impact on practice before signing
- Evaluate what you have versus what you would like to have
- Never give up on your objectives

Case Study 2

Background

- 100 plus providers in multi-specialty group practice
- Very lucrative managed care contracts
- Were not able to evaluate contract performance
- Growing amount of HDHPs and Self-Pay Patients
- New physicians were productive, but overall revenue was low
- Contract rates (fee schedules) were loaded in information system

Practice's Financial Indicators

Annualized charges:	$152MM
Annualized collections:	$88MM
90 day CvC	84%
180 day CvC	89%
Gross Collection %:	57.9%
A/R per physician:	$523,000 (versus a target of $83,095)

Analysis of Claims on Hold

Claims on Hold in A/R	$20,591,615
Claims on Hold due to “Review”	$8,745,533
“Review” Hold Claims as a % of Total	42%
Remaining Claims on Hold	$11,846,081
0-365 Days	$4,644,686
365+ Days	$7,201,394
% of Remaining Claims on Hold >365 Days	61%

Reviewed Claims in Process

Sum of Amount Bal Due		Age Category			
FULL NAME	Claim Stat	31 to 60 Days	61 to 90 Days	91 to 120 Days	Grand Total
MEDICARE	In-process	$ 23,973.04	$ 37,084.28	$ 15,439.59	$ 76,496.91
	No Responnse	$ 258,249.62	$ 186,774.55	$ 202,092.83	$ 647,117.00
	Sent Electronically	$ 145,234.25	$ 72,991.98	$ 66,662.39	$ 284,888.62
MEDICARE Total		**$ 427,456.91**	**$ 296,850.81**	**$ 284,194.81**	**$ 1,008,502.53**
OXFORD	In-process	$ 40,106.70	$ 34,787.02	$ 16,958.51	$ 91,852.23
	No Responnse	$ 58,732.86	$ 145,099.43	$ 139,146.16	$ 342,978.45
	Sent Electronically	$ 480,807.50	$ 51,309.59	$ 30,086.00	$ 562,203.09
	Self-Pay	$ 4,655.00			$ 4,655.00
OXFORD Total		**$ 584,302.06**	**$ 231,196.04**	**$ 186,190.67**	**$ 1,001,688.77**
US HEALTHCARE	In-process	$ 20,806.97	$ 8,070.38	$ 20,215.80	$ 49,093.15
	No Responnse	$ 216,451.19	$ 214,905.55	$ 255,289.87	$ 686,646.61
	Sent Electronically	$ 122,568.71	$ 11,796.60	$ 15,857.00	$ 150,222.31
	Self-Pay	$ 10,936.00	$ 9,138.00		$ 20,074.00
US HEALTHCARE Total		**$ 370,762.87**	**$ 243,910.53**	**$ 291,362.67**	**$ 906,036.07**
CIGNA	In-process	$ 115,189.46	$ 58,432.33	$ 32,927.84	$ 206,549.63
	No Responnse	$ 86,720.12	$ 89,912.13	$ 45,614.55	$ 222,246.80
	Sent Electronically	$ 117,825.25	$ 48,294.15	$ 32,637.00	$ 198,756.40
	Self-Pay		$ 1,300.00		$ 1,300.00
CIGNA Total		**$ 319,734.83**	**$ 197,938.61**	**$ 111,179.39**	**$ 628,852.83**
UNITED HEALTHCARE	In-process	$ 41,553.54	$ 46,125.79	$ 23,204.87	$ 110,884.20
	No Responnse	$ 39,172.78	$ 32,004.46	$ 68,023.18	$ 139,200.42
	Sent Electronically	$ 286,939.76	$ 37,662.29	$ 24,001.00	$ 348,603.05
	Self-Pay	$ 1,114.00	$ 424.00	$ 778.00	$ 2,316.00
UNITED HEALTHCARE Total		**$ 368,780.08**	**$ 116,216.54**	**$ 116,007.05**	**$ 601,003.67**
AETNA	In-process	$ 23,229.72	$ 16,998.39	$ 15,197.47	$ 55,425.58
	No Responnse	$ 46,764.15	$ 36,471.47	$ 68,687.87	$ 151,923.49
	Sent Electronically	$ 122,025.75	$ 11,078.60	$ 12,144.54	$ 145,248.89
	Self-Pay	$ 2,145.00	$ 859.00	$ 797.17	$ 3,801.17
AETNA Total		**$ 194,164.62**	**$ 65,407.46**	**$ 96,827.05**	**$ 356,399.13**
HEALTHNET	In-process	$ 22,445.47	$ 18,014.75	$ 12,305.21	$ 52,765.43
	No Responnse	$ 34,915.52	$ 43,786.46	$ 50,179.34	$ 128,881.32
	Sent Electronically	$ 129,909.04	$ 8,672.00	$ 5,542.65	$ 144,123.69
HEALTHNET Total		**$ 187,270.03**	**$ 70,473.21**	**$ 68,027.20**	**$ 325,770.44**
PRIVATE HEALTHCARE SYST	In-process	$ 65,201.00	$ 17,043.00	$ 34,726.00	$ 116,970.00
	No Responnse	$ 3,489.62	$ 4,028.26	$ 3,963.70	$ 11,481.58
PRIVATE HEALTHCARE SYSTEMS Total		**$ 68,690.62**	**$ 21,071.26**	**$ 38,689.70**	**$ 128,451.58**
SELF PAY	In-process	$ 7,584.00	$ 20,193.11	$ 13,688.22	$ 41,465.33
	No Responnse	$ (81.65)		$ (16.34)	$ (97.99)
SELF PAY Total		**$ 7,502.35**	**$ 20,193.11**	**$ 13,671.88**	**$ 41,367.34**
Grand Total		$ 2,528,664.37	$ 1,263,257.57	$ 1,206,150.42	$ 4,998,072.36

Financial Impact

- Insurance - Reimbursed at Contracted Rates
- Financial impact of an estimated $4-5M net collection recovery
- Claims identified as not being paid at contracted rates equal over $8.7M in gross charges (Calculation assumes ability to collect 50-60% of claims)
- A great majority of 1 Time Improvement $ will come from resolving underpaid claims

Financial Impact

- Increase in Self-pay Collections
- Through improved back-end process and adjustment of front-end functions, the group can improve performance in the self-pay collection department by at least $500K per year
- Setting of individual monthly targets
- Improved productivity
- Tracking of collections

Developed Key Metrics to Measure Business Functions

Practice Vitals

Indicator Category	Nov-05	Dec-05	Jan-06	Avg - 13 Mth	Benchmarks*
Business Days per Month	20	21	20	21	21
Overall Performance					
Collected vs Collectible--90 day	92.86%	91.13%	89.92%	90.53%	94.00%
Collected vs Collectible--180 day			95.64%	95.64%	96.00%
Gross Charges	$14,393,129	$14,638,570	$15,415,122	$14,574,706	$12,496,918
Gross Charges per day	*$719,656*	*$697,075*	*$770,756*	*$702,462*	*$595,091*
Total Receipts	$7,743,368	$6,105,804	$13,127,454	$9,173,791	$8,827,336
Total Receipts per Day	*$387,168*	*$290,753*	*$656,373*	*$442,761*	*$420,349*
Accounts Receivable Performance					
Total Gross A/R	$32,859,064	$37,300,381	$28,676,301	$34,172,088	$26,547,745
Insurance A/R	$31,673,603	$36,309,833	$27,303,000	$32,569,965	$25,058,898
Self-Pay A/R	$1,185,461	$990,548	$1,373,301	$1,602,123	$1,488,846
Total Days in A/R	68.51	77.49	58.07	70.46	62.00
A/R 0 - 30	$12,862,825	$13,629,950	$12,901,111	35.52%	63.90%
A/R 31 - 60	$3,572,526	$9,235,346	$2,745,868	10.12%	14.30%
A/R 61 - 90	$1,551,588	$1,795,920	$1,530,475	4.43%	7.50%
A/R 91- 120	$975,267	$943,830	$1,269,271	3.25%	4.00%
A/R 121+	$13,896,857	$11,695,335	$10,229,576	46.67%	10.10%
Total Dollar Claims on Hold (2004 Activity)	$10,671,912	$9,421,383	$8,220,612	$10,254,876	
Claims on Hold as % of Pending Claims (2004)	37.41%	27.21%	35.39%	38.74%	
Denial Rate - Excludes NCR	2.44%	2.36%	8.41%	5.46%	
Fastnotes Edit Management					
Total Dollar Submitted Edit Rate	2.75%	0.62%	1.31%	1.42%	3.00%
Total Claims Submitted Edit Rate	2.11%	0.37%	0.69%	0.89%	1.00%
Charge Processing (lag days)					
Office	5.37	4.41	6.64	8.72	5.00
Inpatient	12.81	15.03	12.77	15.77	8.00
Outpatient	9.49	7.98	13.76	12.37	6.00
Collections Percentage					
Insurance CvC--90 day	93.33%	92.22%	89.23%	91.18%	94.00%
Insurance CvC--180 day			96.28%	96.28%	96.00%
Medicare CvC--90 day	94.99%	91.32%	96.83%	93.27%	98.00%
Medicare CvC--180 day			96.95%	96.95%	96.00%
Self-Pay CvC--90 day	80.23%	74.48%	74.68%	74.11%	90.00%
Self-Pay CvC--180 day			83.28%	83.28%	
% of Patients Cashiered	84.80%	85.56%	85.59%	85.89%	90.00%
Time of Service Office Collections	79.55%	81.85%	83.40%	82.12%	80.00%

Establish CvC Indicators by Plan

NOVEMBER, 2005 INSURANCE PLAN	CHARGES	ALLOWABLE	COLLECTED	(Coll./Allow.) % COLLECTED
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Practice Results

- Deployed aggressive front-end verficiation and collection activities
- Claim edits/rejections were reviewed and tracked for analysis
- Evaluated CvC by Payer and tracked results
- Accountability for data integrity
- Created financial indicators and targets by functional area
- Established overall CvC indicators and built into practice's budget

Summary

- "Best performing" groups have ability to adapt to changes in the market
- Consumer-driven healthcare will continue to have an expanding presence
- High deductible health plans along with HSAs, HRA, and FSA will force more patient responsibility
- Organizations that can expand their upfront collection efforts will adapt well to HDHP
- Include monitoring tools to evaluate collection success and payer reimbursement
- Incorporate changes in your operational processes sooner than later

Questions

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