Managing Non-Medicare Patients to Maintain Profitability

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Sta-Home Health and Hospice

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Homecare Homebase

Moderated by Ken Willman
ZirMed, Inc.

Our Discussion For Today

- Explain the challenges that Sta-Home faced that led to a reduced payment rate
- Describe the best practices that Sta-Home implemented to increase its management approach for non-Medicare patients
- Demonstrate how Sta-Home streamlined its claims management approach resulting in faster payment

How one home health and hospice provider implemented policies, procedures, and tools to uncover inefficiencies and increase the organization’s payment rate.
Who We Are: Carole

- Carole Grantham
  Director of Billing Operations
  Sta-Home Health and Hospice

- 25+ years with Sta-Home
  - Implemented 3 different software systems
  - Responsible for all billing and collection since 1994
  - Implemented new State and Federal regulations and payer requirements

Who We Are: Matt

- Matt McCarthy
  Sales Account Executive
  Homecare Homebase (HCHB)

- Long time member of the HCHB financial consulting team
  - Training users on billing, accounting, and reporting functionality
  - Expert in helping clients maximize the financial health of their business
Who We Are: Ken

- Ken Willman
  VP Payer Solutions and Strategy
  ZirMed, Inc.

- 10 years on the provider side

- 13 years on the payer side
  - Expert in provider workflow, administrative, and cash flow enhancement through technology

- 2+ years with ZirMed

Introducing Sta-Home

- Sta-home Health Agency founded in 1976

- Dedicated to helping families across Mississippi

- The state's largest privately owned home health provider

- Comprehensive services for homecare and hospice
Sta-Home Overview of Operations

- Our payer mix:
  - 95%+ traditional Medicare and episodic Medicare Advantage plans
  - < 5% of patients covered by commercial insurance and Medicaid

- We considered the pay per visit <5% a cost of doing business
  - It’s a small percentage of patients, right?

- Patient-focused culture
  - No difference to our nurses and therapists if patient was pay per visit (PPV) or prospective payment system (PPS)
  - Why should we manage those patients differently?

But Our Industry Was Changing

- Payers started changing their payment methodologies:
  - In 2011, some Medicare Advantage plans in MS moved from PFFS to HMOs
    - This changed the payment method to pay per visit
    - Authorization of services became a requirement
  - In 2014, the largest Advantage plan in MS moved to pay per visit
  - Mississippi Medicaid increased the transition of patients to managed care

- Sta-Home needed to review all processes, procedures, and resources related to the changing payment models
And We Were Facing Challenges

- Spending too much time handling payers without contracts
- Unacceptable payment rates
- Uncollectable deductibles and co-pays

Result was growing inefficiencies and decreased payment rates

What Was Really Going On

- Payer contracts were not in alignment with claim requirements for payment
  - Example: Negotiated rates for services that cannot be identified as part of the claim requirements
- Payer contracts not properly set up
  - Resulted in rejected/denied claims
  - Negotiated rates were unknown to those responsible for A/R follow-up.
  - DSO was widely varied and over 120 days
What Was Really Going On

- Authorization requirements not widely known
  - Visiting staff may provide services not authorized by the payer

- Management of supporting documentation was poor

- Patient deductibles and co-pays were not discussed with patients prior to admission
  - Resulting in extremely low collections

Our Solution: Implement Best Practices
Process Changes

- Select team created to streamline processes for benefits, eligibility, and authorizations
  - Employees most knowledgeable on guidelines and requirements for each payer

- Contracted rates now entered by payer to evaluate compliance

- Deductibles and co-pays are discussed with patients prior to admission resulting in higher collections.

Process Changes

- Payer performance is closely monitored
  - Trends in erroneous denials or inaccurate rates are addressed with Provider Relations staff for resolution

- We communicate that we put patients first
  - Payers whose processes and requirements do not allow us to provide quality care for the patient in the home are notified in writing that we can no longer do business with them.
Resource Changes

- Responsibility for all commercial insurance contracts moved to the Billing Director
  - All negotiations for rates, billing requirements, timely filing standards, etc.. are uniform
  - Negotiated with payers to remove redundant requirements
    - Example: notes required for authorization and claims processing

- Certified Case Managers provide clinical oversight and guidance from referral to discharge
  - Ensures payer requirements are met
  - Maximizes authorization for services
  - Educate visiting staff on medical necessity

Technology Changes

- Maintain billing and financial records within Homecare Homebase
  - Added benefit: we “went green” by reducing paper

- Use ZirMed for electronic verification of benefits
  - Resource benefits: fewer employees spending hours on hold with phone calls

- Claims, patient invoices, and payments are processed mostly electronically
  - Payers without electronic capabilities are kept to a minimum to reduce administrative cost
Results for Sta-Home

- Percentage of billed charges collected versus adjusted:

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collected</td>
<td>57%</td>
<td>57%</td>
<td>71%</td>
<td>65%</td>
<td>81%</td>
<td>72%</td>
</tr>
<tr>
<td>Adjustment %</td>
<td>43%</td>
<td>36%</td>
<td>32%</td>
<td>35%</td>
<td>28%</td>
<td>29%</td>
</tr>
</tbody>
</table>

- DSO changes for top 6 payers:

<table>
<thead>
<tr>
<th>Payer</th>
<th>12/31/2011</th>
<th>6/30/2014</th>
<th>Decrease in DSO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer 1</td>
<td>73</td>
<td>53</td>
<td>27%</td>
</tr>
<tr>
<td>Payer 2</td>
<td>63</td>
<td>36</td>
<td>42%</td>
</tr>
<tr>
<td>Payer 3</td>
<td>40</td>
<td>30</td>
<td>25%</td>
</tr>
<tr>
<td>Payer 4</td>
<td>110</td>
<td>34</td>
<td>69%</td>
</tr>
<tr>
<td>Payer 5</td>
<td>175</td>
<td>37</td>
<td>79%</td>
</tr>
<tr>
<td>Payer 6</td>
<td>89</td>
<td>80</td>
<td>10%</td>
</tr>
</tbody>
</table>

But We Didn’t Do It Alone
**Homecare Homebase**

- Built in audits to ensure compliance
- Up front contractual adjustment entry
  - Reduces need to post adjustments on every visit during cash posting
  - Allows a properly recognized AR at the end of the month instead of having to build a giant reserve
- Batch billing
  - Create claims for all payer sources all at once
  - Batch claims appropriately (Institutional v Professional, by payer, etc.)
- Easy 837 configuration with ZirMed
  - HCHB has the ZirMed requirements integrated into the payer setup to allow for easy 837 file creation

**Homecare Homebase**

- 835 import for all payers
  - Allows quick posting of cash
- ZirMed can convert paper payments into electronic so that all payments can be imported
- Easy collection process with notes and alerts
  - Allows users to easily know when invoices are “past due”
- Reduced DSO
How Your Claims Partner Can Help

- Complete electronic verification of benefits and eligibility
- Be your insurance clearinghouse for transmission of all commercial insurance claims
  - Include claims for payers without electronic capabilities
- Get you immediate response from payers for claim correction and resubmission
- Deliver electronic remittance advices
- Stuff and mail patient invoices

Conclusions

- The industry is changing every day – make sure you are prepared!
- Evaluate processes, resources, and technology constantly
  - Are they adapting to the changing dynamics in your local area?
- Don’t depend on payers to inform you of changes!
  - Monitor payer website weekly
  - Have a good clearinghouse partner who monitors as well
Conclusions

- Communicate and collect from patients as early as possible

- Maintain relationship with payer representatives
  - Address redundant requirements and tactics designed to make authorization and payment more difficult

- Partner with good technology vendors – you don’t have to do it alone!

Questions?

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