

How providers collect revenue during COVID and beyond



Andrew Harding



Andrew is the Vice President of customer success at Rivet. His primary function is supporting Rivet's customer in learning, implementation and adoption of Rivet from patient cost transparency to navigating the waters of insurance contracts. He brings over a decade of revenue cycle experience to support process and organizational change.

Agenda

1. Modeling impact and identifying levers
2. Implementing pricing transparency
3. Accelerating patient cash

Measuring impact

97% experienced negative financial impact from COVID-19 ([MGMA](#))

55% average decrease in revenue ([MGMA](#))

60% decrease in patient volume ([Phreesia](#))

5x increase in telehealth visits ([AMA](#))

Shifting reimbursement – 2019 > 2020 CMS National CBSA

Code	Description	ASC 2019	ASC 2020	\$ Change	% Change
64580	Implant neuroelectrodes	\$ 9,359.93	\$ 17,039.28	\$ 7,679.35	82.04%
37184	Prim art m-thrmbc 1st vsl	\$ 2,913.00	\$ 6,429.68	\$ 3,516.68	120.72%
22612	Lumbar spine fusion	\$ 5,281.63	\$ 8,607.58	\$ 3,325.95	62.97%
24365	Reconstruct head of radius	\$ 5,281.63	\$ 8,586.83	\$ 3,305.20	62.58%
27429	Reconstruction knee	\$ 7,043.45	\$ 10,113.69	\$ 3,070.24	43.59%
27443	Revision of knee joint	\$ 5,281.63	\$ 8,266.66	\$ 2,985.03	56.52%
28130	Removal of ankle bone	\$ 1,256.79	\$ 4,183.66	\$ 2,926.87	232.88%
23406	Incise tendon(s) & muscle(s)	\$ 1,256.79	\$ 4,018.71	\$ 2,761.92	219.76%
23491	Reinforce shoulder bones	\$ 5,281.63	\$ 8,004.80	\$ 2,723.17	51.56%
27428	Reconstruction knee	\$ 5,281.63	\$ 7,717.14	\$ 2,435.51	46.11%
29889	Knee arthroscopy/surgery	\$ 5,281.63	\$ 7,661.63	\$ 2,380.00	45.06%
24575	Treat humerus fracture	\$ 5,281.63	\$ 7,412.67	\$ 2,131.04	40.35%
62287	Percutaneous diskectomy	\$ 1,920.83	\$ 796.79	\$ (1,124.04)	-58.52%
64831	Repair of digit nerve	\$ 1,920.83	\$ 796.79	\$ (1,124.04)	-58.52%
64861	Repair of arm nerves	\$ 1,920.83	\$ 796.79	\$ (1,124.04)	-58.52%
28555	Repair foot dislocation	\$ 4,051.33	\$ 2,803.36	\$ (1,247.97)	-30.80%
64885	Nerve graft head/neck </4 cm	\$ 3,575.47	\$ 2,170.24	\$ (1,405.23)	-39.30%
24115	Remove/graft bone lesion	\$ 4,212.26	\$ 2,803.36	\$ (1,408.90)	-33.45%
69715	Temple bne implnt w/stimulat	\$ 12,225.21	\$ 10,770.96	\$ (1,454.25)	-11.90%
36260	Insertion of infusion pump	\$ 3,969.54	\$ 2,321.81	\$ (1,647.73)	-41.51%
27709	Incision of tibia & fibula	\$ 7,391.44	\$ 5,727.13	\$ (1,664.31)	-22.52%
27396	Transplant of thigh tendon	\$ 4,470.05	\$ 2,803.36	\$ (1,666.69)	-37.29%
24362	Reconstruct elbow joint	\$ 8,178.88	\$ 5,727.13	\$ (2,451.75)	-29.98%
22869	Insj stablj dev w/o dcprn	\$ 12,597.93	\$ 9,874.82	\$ (2,723.11)	-21.62%

Source: cms.gov section 508 ASC payment rate addenda

Implementing pricing transparency

83%

of Physician Practices under five practitioners said the slow payment of high-deductible plan patients are their top collection challenge

67%

of Americans are either very worried or somewhat worried about unexpected medical bills

2/3

of patients prefer electronic payment methods to pay their medical bills

81%

of Physician Practices have difficulty communicating patient payment accountability

Why is it difficult?



Knowing your
out-of-pocket
liability



Getting care
and receiving
a bill 30-45
days later

- “Bill me later” mentality
- Physician bills paid after hospital bills
- Resources of practices to collect
 - Average statement size
- Typically many provider options

Create an estimate



- Use either your actual contracted rates, or analytics from remittance data (payment data)
- Pair scheduled services with benefits & eligibility
- Clear and transparent patient responsibility
- Modern-friendly delivery

One way...

The screenshot shows a web browser window with the URL `app.rivetedemo.com/accounts/1/patients/patients/1815/estimations/578`. The page title is "Patients / Testington, Test / Estimates / Estimate". The main content is divided into several sections:

- Patient:** Testington, Test (Edit patient)
- Treatment:** Provider: Souss, Dr. - 9999...; Facility: Default - 123 Fake Street...; Service Date: 10/28/2020
- Insurance:** Service types: Health Benefit Plan Coverage - 30; Primary service type: Health Benefit Plan Coverage - 30
- Primary - Self Pay/No Insurance (9999999):** In-network; Out-of-network. A warning message states: "This payer is not configured for eligibility checks. Contact support".
- Fee schedule:** Self Pay/No Insurance - Self Pay/No Insurance
- Deductible:** \$ 0
- Out-of-pocket:** \$ 0
- Copayment:** \$ 0
- Coinsurance:** 0
- Codes:** Advanced
- Service template:** Select a service template

On the right side of the page, there is a "Patient estimate" table:

Item	Amount
Patient estimate	\$56.49
99213 allowed (1)	\$56.49
Total allowed	\$56.49
Patient copay	\$0.00
Patient deductible	\$0.00
Patient coinsurance	\$56.49
Insurance payment	\$0.00

Buttons for "Copy to New", "Download", "Send email", "Send SMS", and "View" are located above the table.

The screenshot shows a smartphone screen with a text message from "Demo Account Template" (+1 (321) 341-2525). The message content is:

Demo Account Template would like to text you at this phone number about your health. Please visit <https://app.rivetedemo.com/view/ES0072995> to indicate your communication preferences.

Your estimate from Demo Account Template is ready. Tap here to view: <https://app.rivetedemo.com/view/ES0072995>

Your estimate from Demo Account Template is ready. Tap here to view: <https://app.rivetedemo.com/view/ES0072995>

Below the message, there is a "Bright Family" logo and a notification: "You have given Template your health information". A button labeled "Update preference" is visible.

The phone's home screen shows various app icons, including Messages, Photos, and the "REFLECTOR 3" app. A watermark for "REFLECTOR 3" is visible at the bottom of the phone screen.

Accelerating patient cash

“For the first time in my experience managing a practice, our patient A/R is greater than our insurance A/R”

“Our patient A/R over 90 makes up 40% of our open A/R”

“Collecting from patients will continue to be a threat to the independent physician practice.”

Metrics impacted



Point-of-service (POS) cash



Total patient cash



Patient A/R



Bad debt write-offs



Dormant patient accounts (no payment in 60 days)



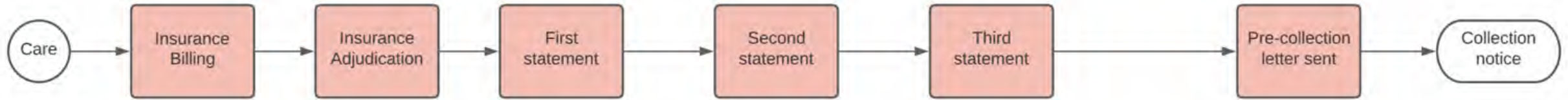
Patient experience/patient satisfaction

Communicate balances early on

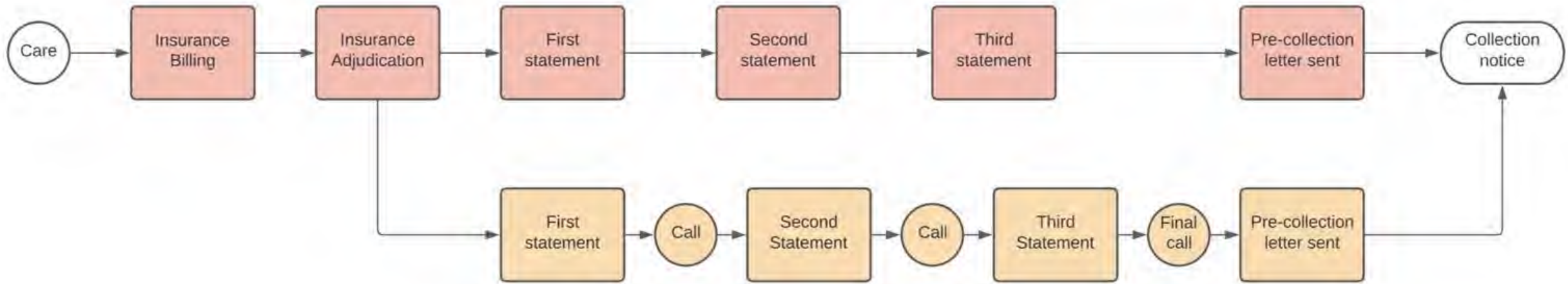


- Communicate costs prior to service
 - Transparency enhances patient experience
- Communicate payment policies (payment in full, payment plan)
- If a patient is concerned about the cost pre-service, that would not change post-service

Design an effective process

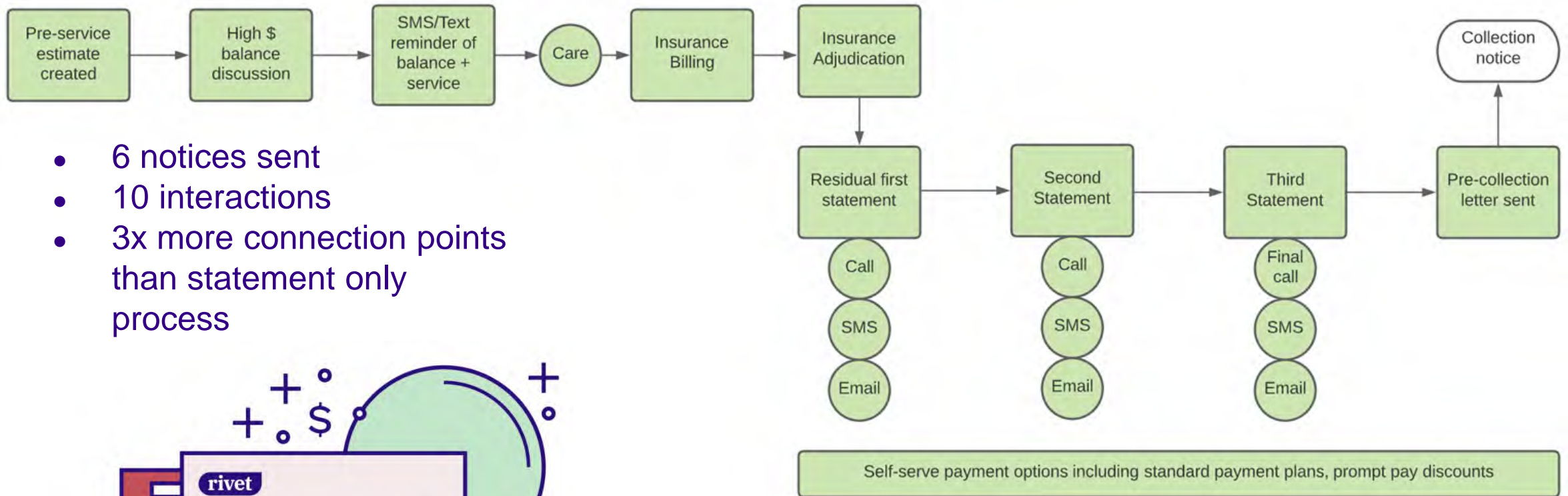


5 notices sent, 0 interactions

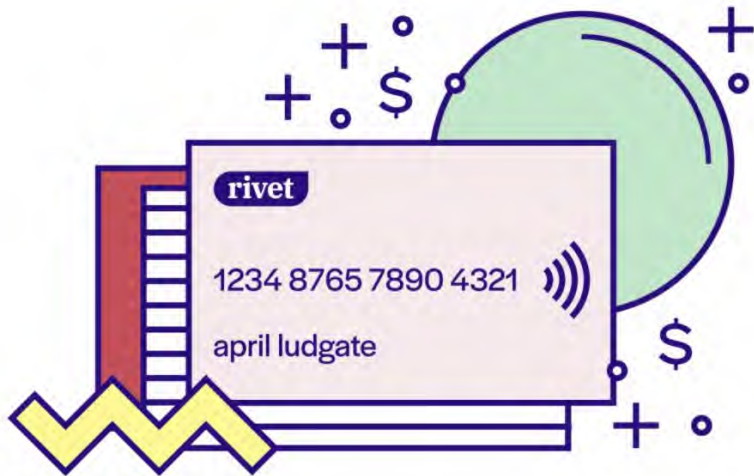


5 notices sent, 3 interactions

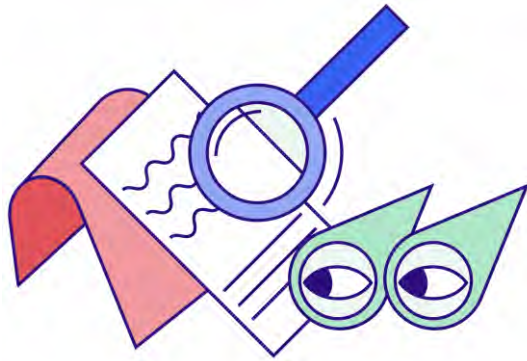
But, what if?



- 6 notices sent
- 10 interactions
- 3x more connection points than statement only process



Paying bills has changed, so should your process



✓ Simplify patient understanding of bills



✓ Standardize payment options and rates



✓ Make it easy for your patients to pay

Simplify payment standardization

Brighton Family Health

Create a new payment plan

Enter payment amount ⓘ

\$1,200


Paid today

\$0

Select a term

6 months **\$200 /mo**

Continue

 Powered by Rivet



Brighton Family Health

Summary


Monthly payment **Due today**
\$120/month \$150

Method	Term	Date
Visa 4525	12 months	11th

Communication
jim@dundermifflin.com


By clicking Enroll, you authorize Rivet to charge your credit card today and automatically each month until your balance is paid.

Enroll

 Powered by Rivet




Brighton Family Health



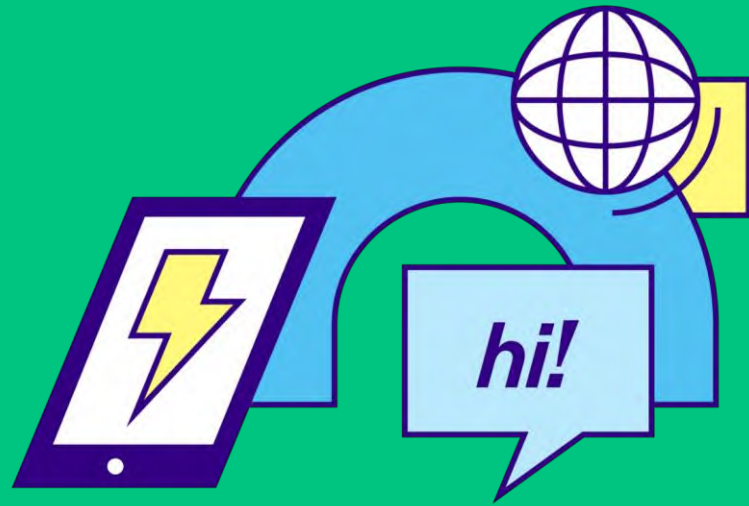
You're enrolled!

\$150 was charged to Visa 4456

Your card will be charged automatically each month

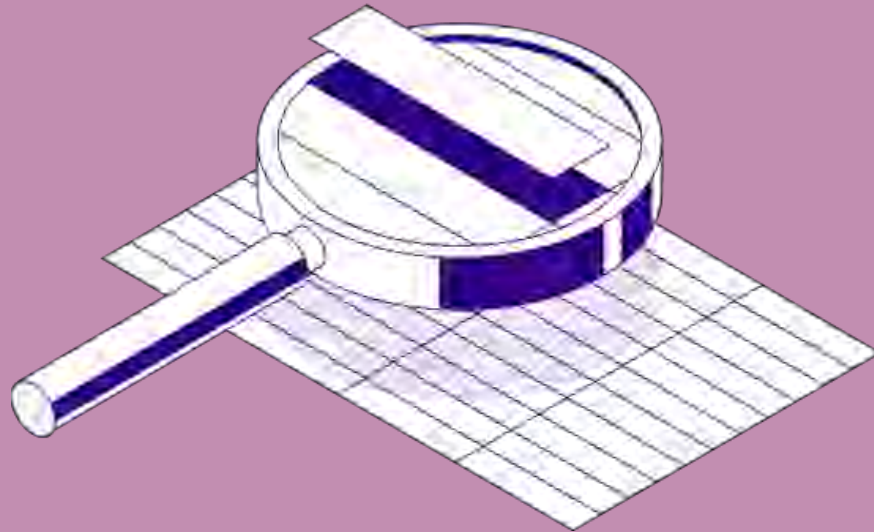
 Powered by Rivet

Make it easy to pay



- Modern payments are so easy, incorporate these!
 - Mobilepay
 - Web-pay
 - Flexible cards (HSA/FSA, Debit, Credit)
 - Card-on-file auto payments
 - Patient driven payment plans
- Provide multiple avenues for a patient to pay
 - Phone line
 - Portal/web based
 - Point of service

Identify at-risk patient accounts



Balance Flags:

- Balance over 60 no payments (low risk)
- Balance over 90 no payments (medium risk)
- Balance over 120 no payments (high risk)

Transaction Flags:

- 2 Failed auto-payments
- More than 2 balances sitting in collections/bad debt
- Minimum auto-payment much lower than targeted minimum (longevity of A/R)

Dunning level/rick levels

- Changing strategy based on age of balance
- Consider A/R partitions for “early out”

Clean-up of A/R

1. Balance corrections

1. Patient credit = patient debit
2. Patient credit with a corresponding balance

2. Low hanging fruit

1. One time patient prompt-pay discounts on aged balances
2. Establishing standard payment plans on aged balances
3. Determine bad-debt or third party

3. Foundational progress

1. Align with practice stakeholders on financial policies
 1. Payment plan duration, interest bearing, balance thresholds etc..
 2. Financial assistance policies/Financial counselor review
2. Develop an upfront financial transparency goal (certain States are pre-empting)



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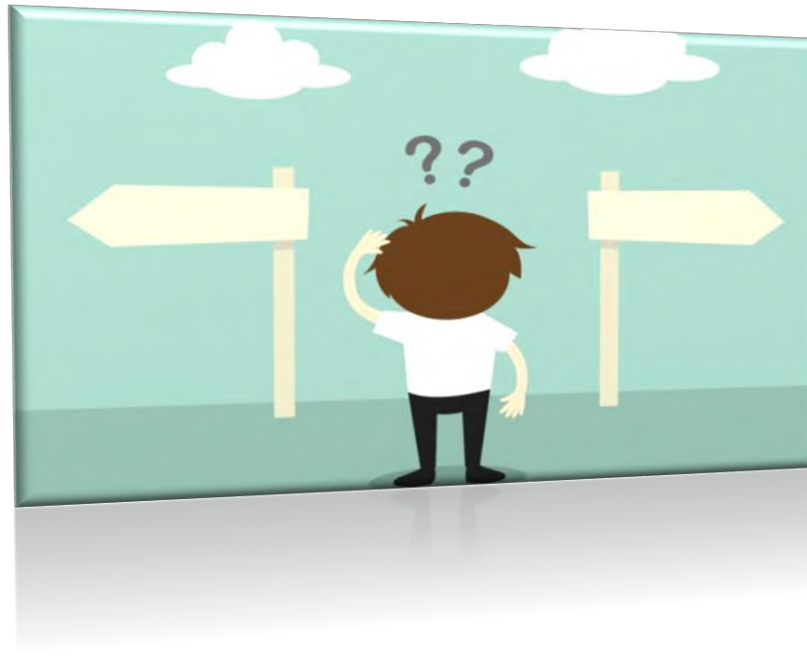
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Today's Agenda

- Deciding to participate in a plan
- Negotiating the contract
- Analyzing contract terms and avoiding pitfalls
- Pursuing dispute resolution

Deciding to Participate



Deciding to Participate

- Can a patient elect to use an out-of-network ASC?
 - HMO
 - No
 - PPO
 - Yes
- ASCs should assess the penetration of the particular payor in their service area.
- ASC should perform due diligence on each Payor.
- Participation strategy may differ depending on Payor.

Negotiating the Contract

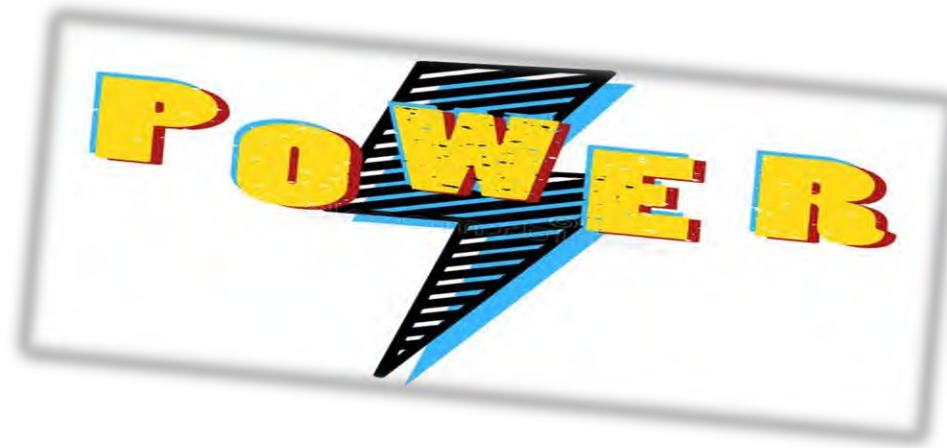


Negotiating the Contract

- Is the ASC in a position to negotiate?
- Negotiating a contract can involve a lengthy process.
- Legal review comes at a cost.
- There is often little variance from standard template.

The Basic Rule

- Managed care contracting is controlled by **POWER**
- Whoever has the power in the relationship, controls the key contract terms
- Managed care plans typically have the power



The Power of ASCs

- ASCs, however, are not powerless
- ASCs have power when they:
 - regularly receive a significant number of referrals to provide services to Payor members, and/or
 - are the only game in town
- ASCs also have power when they are a lower cost alternative

Avoiding Pitfalls

- Regardless of negotiating position, ASCs can avoid contracting pitfalls by:
 - understanding the components of the contract;
 - implementing necessary operational changes to ensure compliance with contract terms; and
 - establishing a cordial relationship with the plan representative.

Four Parts to the Contract

- Participation Agreement
- Compensation Schedule
- Policies and Procedures
- Regulatory Appendices



Analyzing Key Contract Provisions



Term and Termination

- Termination without cause, timeframe
 - Any time?
 - Only upon anniversary date?
- Auto renewal vs. hard end date



Compensation Terms

- Define services and reimbursement rates
- Become familiar with payment policies currently in effect
- Understand reimbursement terms and methodologies
- Confirm advance written notice of reimbursement changes

Claim Submission and Payment

- State prompt pay laws do not always apply
- Payment terms follow the contract
- Submission of claims must be timely
- ASC must confirm accurate payment
- ASC does not have unlimited time to correct incorrect payments



Policies and Procedures

- What lies in the Payor's policies and procedures?
- What controls between the agreement and the policies and procedures?
- How is Payor notifying of material changes to policies and procedures?



Utilization Management

- Preauthorization requirements must be met.



Notices

- Should not be treated as a boilerplate provision
- Specify mailing addresses and emails
- Understand when notices become effective
- Be aware of termination and reimbursement changes requiring a specific type of notice



Amendments

- Unilateral amendments-
 - Who receives that notice?
 - Can the Payor modify reimbursement on notice?
 - What happens if the amendment is unacceptable?

Dispute Resolution

- ASC negotiated a fair contract, but not realizing expected revenue?
 - *Why?*

Causes

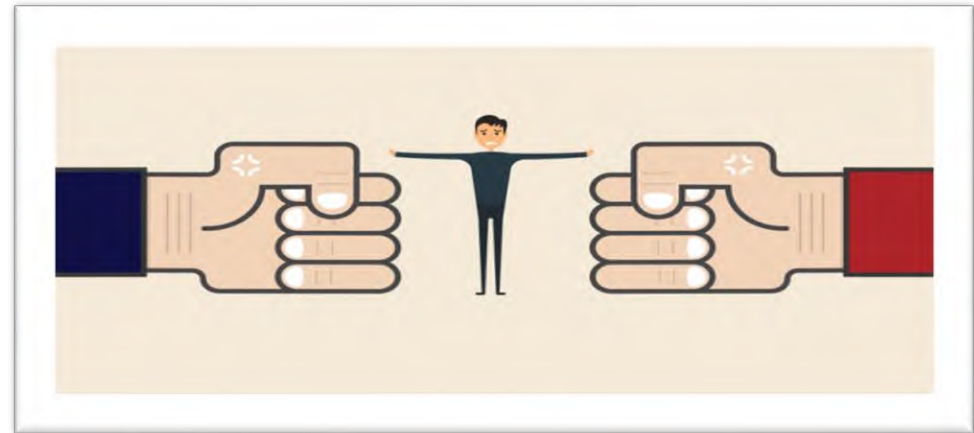
- Payor error
- Confusion or ambiguity about applicable rate
- Pre-certification issues
- Failing to submit clean claims
- Documentation issues
- Cutting-edge services
- Audit activity
- Failing to appeal timely

Avoiding/Resolving Claim Issues

- Time *is not* on your side – promptly process and post all EOBs and claim payments
- Thoroughly understand Payor claim submission rules
- Provide proper documentation with claims
- Document *in writing* all interactions with Payors.
- Understand and carefully follow appeal procedures and deadlines.
- Look for patterns in denials
- Carefully escalate the issues

Dispute Resolution

- Document, document, document
- Follow the processes in contract and policies and procedures
- Ensure compliance with Payor's time frames
- Engage in discussions with Payor representatives
- Involve legal counsel
- Arbitrate if necessary



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YEARS

80+
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