Collecting Low Balances

Squeezing the Toothpaste Tube with Analytics

Peter Angerhofer

Colburn Hill Group

AGENDA

- Introduction
- Analytics Framework
- Low Balance Environment
- Your AR environment
- How to apply analytics
- Low Balance Strategies
- Conclusions

Introduction – Peter Angerhofer

2014- Present Colburn Hill Group

2004-2014 Accretive Health (R1)

2001-2003 Deloitte Consulting

1998-2001 APM/CSC

1991-1996 – U.S. Senate, House of Representatives

MBA, Kellogg School of Management (1998)
BA, Political Science, American University (1991)

How many times could you brush from this tube?

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Purpose of analytics

- To isolate areas of ambiguity
- To separate component parts of a process
- To suggest or identify steps to improve the process or process outcomes

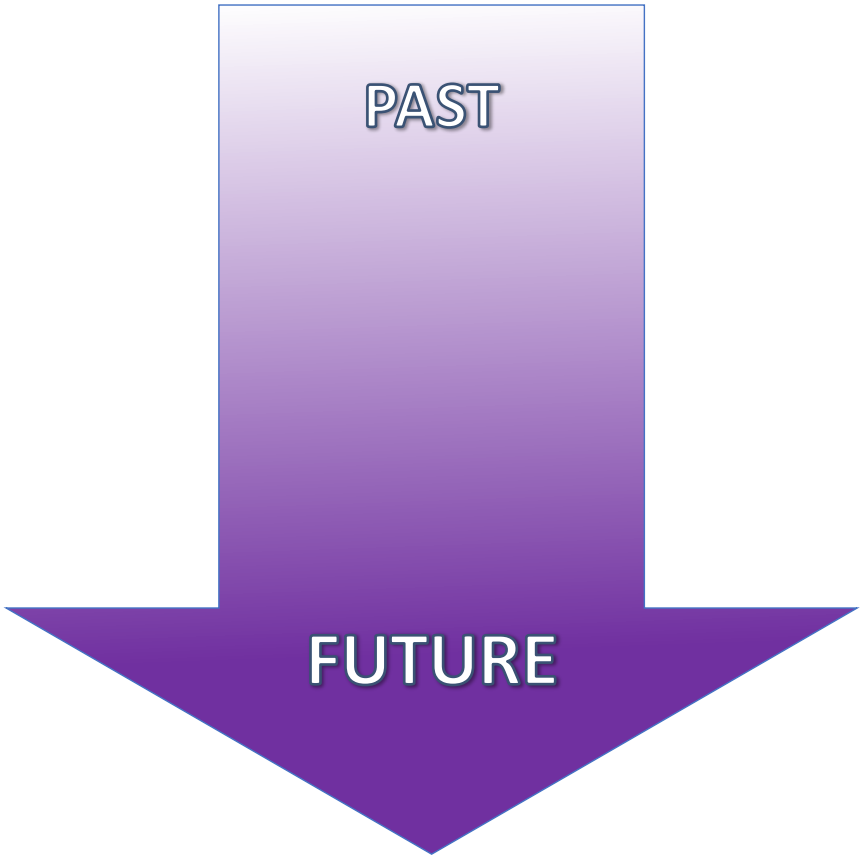
To make a decision

Analytics Framework

Descriptive Analytics

Predictive Analytics

Prescriptive Analytics



Descriptive

Descriptive analytics describe a sample or population

On average, Americans send and receive twice as many text messages as phone calls (Nielsen Mobile)

Based on past experience, Descriptive Analytics tell the story of what happened

Predictive

Predictive analytics use past history to draw conclusions about future outcomes

If you typically charge between $1,000 and $2,000 per month and there's suddenly a $4,500 charge, the company may well refuse the transaction. (Motley Fool)

Predictive Analytics don't generally reflect changes in process or behavior

Prescriptive

Prescriptive Analytics are intended to suggest the best course of action in a given situation

…by taking in seismic data, well log data, production data, and other related data sets to prescribe specific recipes for how and where to drill, complete, and produce wells in order to optimize recovery, minimize cost, and reduce environmental footprint. (Oil and Gas Investor)

Prescriptive Analytics use current information to guide the next actions taken

Decision Making

Descriptive Analytics	*Requires interpretation*
Predictive Analytics	*Based on history, not present*
Prescriptive Analytics	*Suggests specific action*

Common Metrics

- Pre-Registration Rate
- Service Authorization Rate
- Conversion Rate for Uninsured
- POS Cash Collection
- Net Days in A/R
- % AR Aged 90 days and greater
- DNFB
- Bad Debt Write Off %
- Cash Collection
- Case Mix Index
- Write Off

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POP QUIZ!!!

Are these metrics…
Descriptive?
Predictive?
Prescriptive?

Challenges with Common RC Metrics

- Mostly Descriptive
  - Leading indicators, but historically facing
- Significant lag to recognize changes
  - Writeoffs may be years later
- May be contradictory or misleading
  - DNFB reduction could increase % of AR >90 days

Predictive Analytics

- Denials Management and Patient Pay
  - Which balances are worth working?
- If regression is based on past experience, may not have full context
  - Auth denials are written off if no # available in billing system
  - Auth numbers may be in CM or PB system
- Need to incorporate how circumstances may have changed and interpret accordingly

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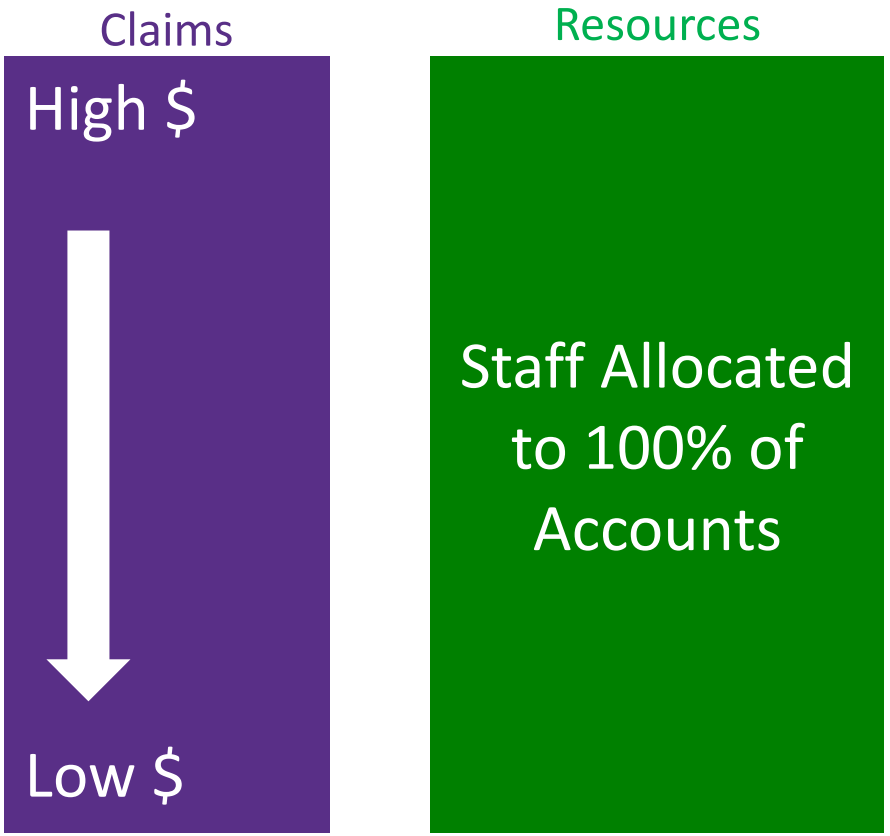
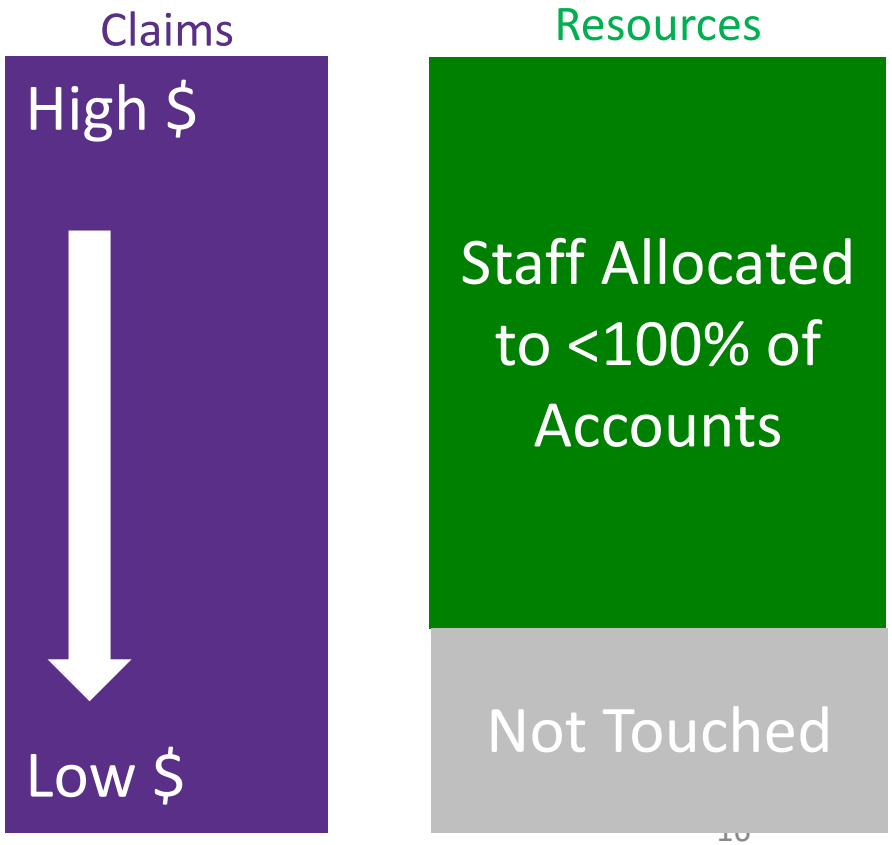
Vicious Circle of Low Balance Claims

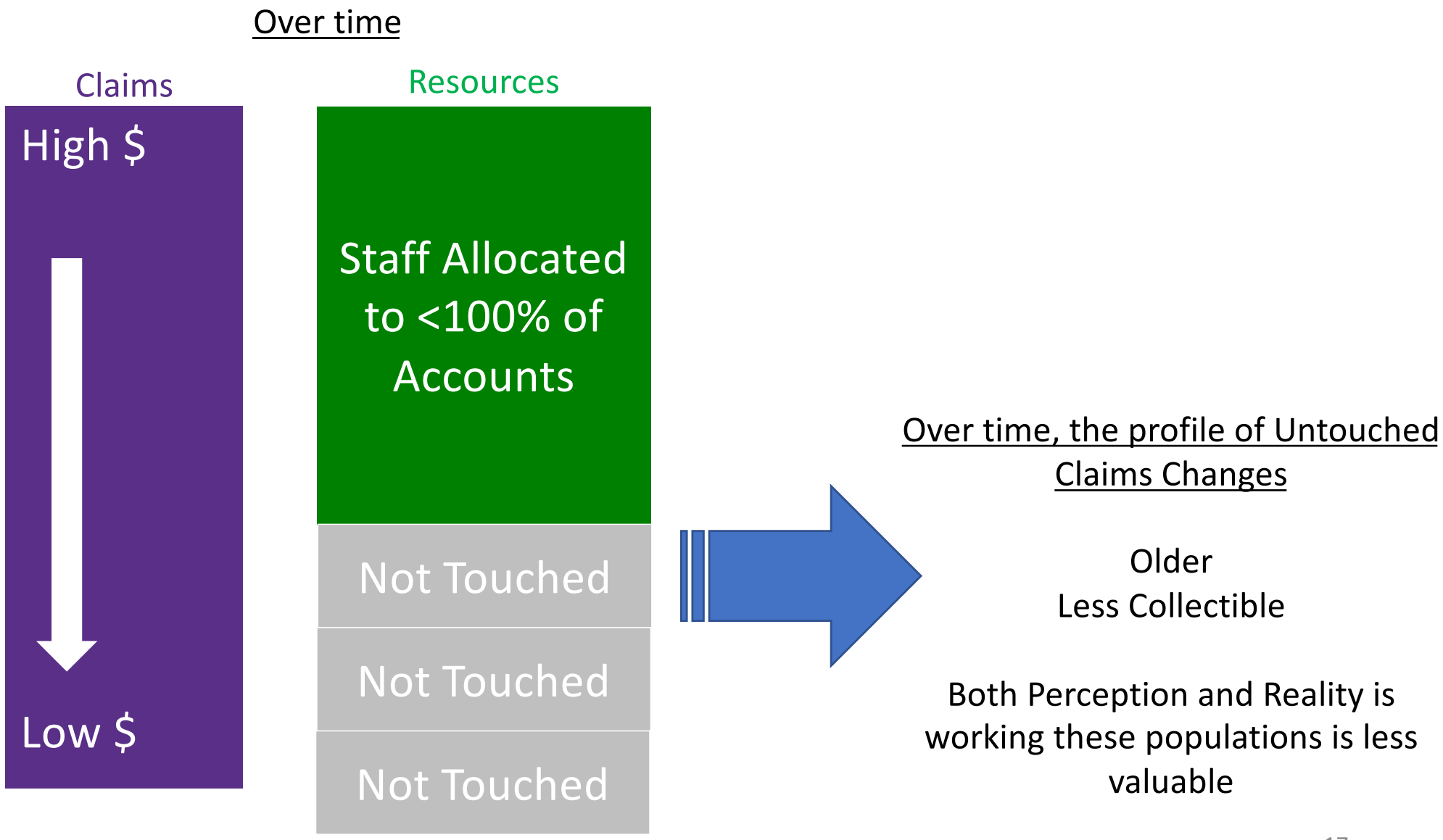
Theoretical Account Assignment



When demand exceeds capacity



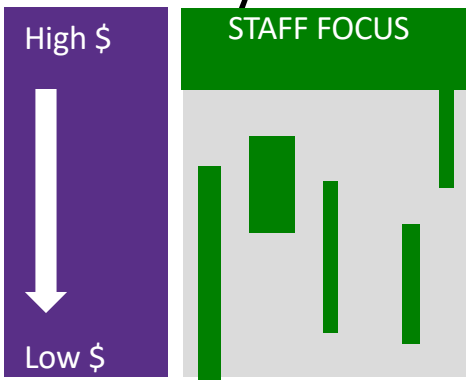
Buildup of Low Balance Claims



Traditional Approaches

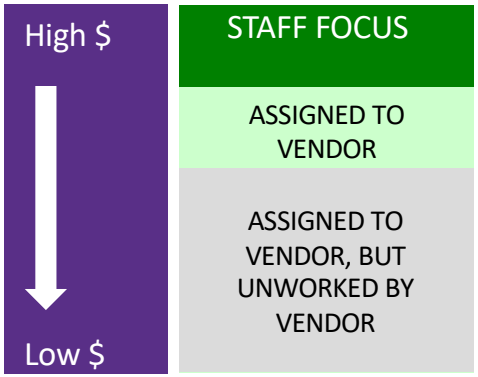
There are a number of approaches to the problem . . .

Work by Issue



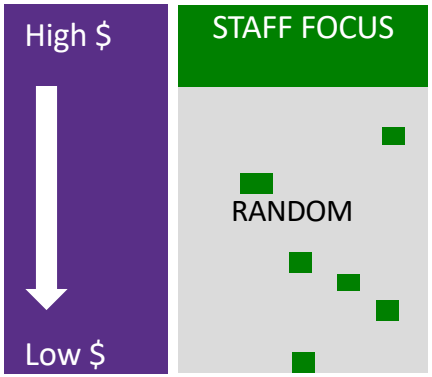
- Assign staff to high value accounts
- Periodic campaigns to work “issues”

Outsource



- Use a vendor to work low balances
- Vendor applies the same 80/20 rule to their inventory

Let Staff Decide



- Assign staff to all accounts
- Focus on high $, but work low $ when they have capacity

. . . but all of them leave accounts unworked, resulting in annual “cleanups” where low balance claims are adjusted off

Step 1: Evaluate Required Follow Up Capacity

The focus of this staffing analysis is *Insurance Follow Up*

To complete this evaluation, calculate your required capacity, as follows:

$$Required\ Capacity = Reg.Volume\ x\ Initial\ Denials\ Rate\ x\ 2$$

$$EXAMPLE:\ Required\ Capacity = 30{,}000\ x\ 10\%\ x\ 2 = 6{,}000$$

Conclusion: to keep AR constant, 6,000 accounts per month must be resolved to $0 balance.

Sources of follow up are: denied claims, unadjudicated (lost) claims, secondary billing issues, paper correspondence, and cash posting errors. Generally, 2x denial rate is a conservative estimate

Step 2: Evaluate Current Follow Up Capacity

Most AR Managers measure staff productivity by "number of accounts worked" (per person per day). A conservative standard is 40 accounts per person per day (800 per person-month).

To calculate your capacity, multiply the number of FTEs (7) doing follow up by 800 and then multiply by 33%

$$Follow\ Up\ Capacity = Average\ Productivity\ x\ 33\%$$

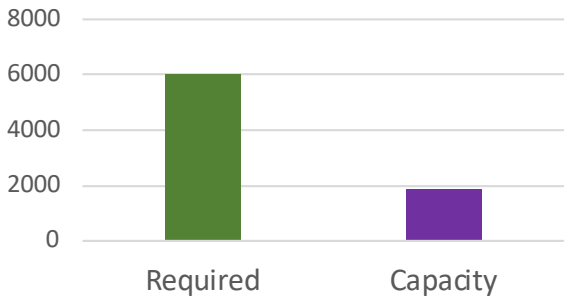
$$EXAMPLE:\ Follow\ Up\ Capacity = 5{,}600\ x\ 33\% = 1{,}866$$

On average, an account that requires follow up is worked 3 times to get the balance to $0. (This is usually due to incorrect follow up, non-productive "touches" and hand offs between staff)

Self Assessment Worksheet

Data Point	Per Month	Notes
Registration Volume		Total number of encounters in a month
Initial Denials Rate	>=10%	In the absence of an active and successful denials management effort, should be 10% or greater
Demand	Volume x Initial Denials x 2	Doubling initial denials accounts for a variety of errors that result in the need for additional followup
# of Follow Up FTEs		Should not include billing, Cash Posting, Customer Service, or other PFS functions
Monthly Productivity	20 days/month X 40 accounts/day = 800	Actual productivity is better than a benchmark, but be sure to exclude an non-follow up activity
Capacity	FTEs x 800 x .33	The average claim requires multiple touches before resolution – here we are estimating 3 touches or an effective rate of 33%
Estimated Untouched Claims	*Demand - Capacity*	The gap between demand and capacity estimates the number of claims that are going untouched *each month*

Step 3: Compare Required to Current Capacity



$$Required\ Capacity = 6{,}000$$

$$Follow\ Up\ Capacity = 1{,}866$$

Actual Capacity is less than 1/3rd the Required Capacity. If this were true, the AR would be growing at an alarming rate …

How can this be?!?

Remember that the distribution of AR is NOT even.
There are far more low dollar accounts than high dollar accounts

ROI Calculation

What balances are “worth” working?

Fully Loaded Labor Cost	$30/hour
Labor Cost/minute	$.50
Average time to work a claim	10 Minutes
Average Cost to work a claim	$5.00
Number of touches required	3-4
Total cost	$20.00

In theory, any claim with an expected reimbursement of $20 or more should be worked

At a 33% Cash to Gross (CTG) ratio, that means a threshold of $60

Adjusted ROI Calculation

Viable percentage	60%
Adjusted Threshold	$20/60% = $33
Mgmt/Infrastructure costs	~$2-$7/claim
New Threshold	$35-$40

*$35 * 33% (CTG) = ~$100*

Our research shows that claims as small as $100 provide a viable ROI and should be worked.

Many organizations ignore claims as large as $5000 because they are "low balance" and do not "justify" the investment to work

The Last Squeeze is…

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Hard

- The 100th pushup is a LOT harder than the first 10

Expensive

- Likely to be lower return than previous squeezes

Easy to Dismiss

- Many claims will have no value

BUT IT IS WORTH IT

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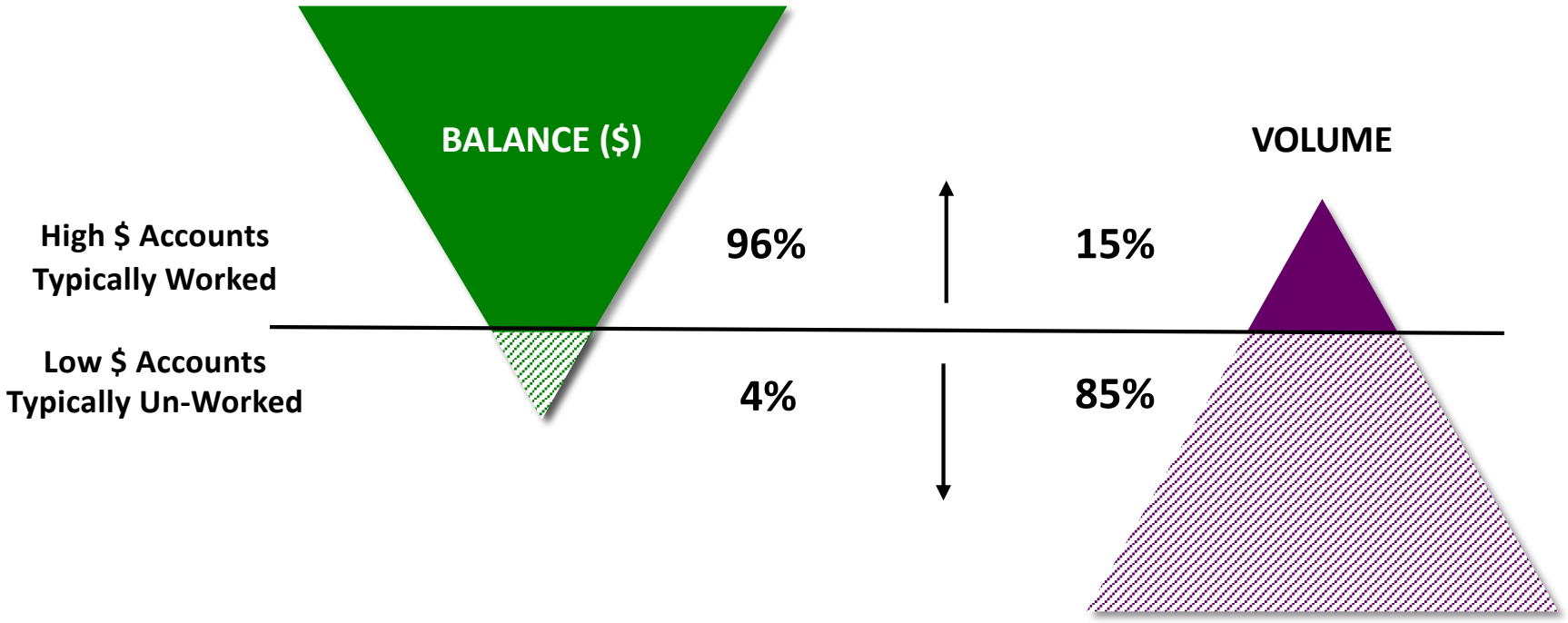
Things about your AR follow up…

You aren’t working most of your AR



40% of your AR has no cash value

- Posting Errors such as missed contractuals
- Claims that have passed filing or appeal limits
- Denials like bundled charges which will not be paid

25% of your AR has a simple cash solution

- Claim was never sent to primary payer
- Claim was never sent to secondary payer
- Balance was never moved to next payer

The next claim is a coin flip

Missed Contractual?

Or Authorization Denial?

Or Late Charge?

Or Registration Error?

Or…

Staff have to make a decision on how to approach follow up

Most staff time spent working claims is wasted

Type of Account	Time Allocation	Action	Research
		40.0%	60.0%
Non-Collectable	40%		
Simple Claims	25%		
Complex Claims	35%		

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How Staff Evaluate Claims

- Aged Trial Balance or Workqueues
- Claim Editor Reports
- Transactions (Charges, Corrections, Payments, Writeoffs, Adjustments, Contractuals)
- 835/837
- Notes/Comments

Decisions require information

- Confirm balance and Payer
- Review history and read comments
- Review charges and any previous adjustments or payments
- Review EOBs

Descriptive

"The last claim with these characteristics got paid when I…" ⇐ Predictive

Example of Staff Thinking

<u>EXAMPLE</u>

Current balance of $2500 is in Third Party FSC

AND

835 indicates a patient balance of $2500

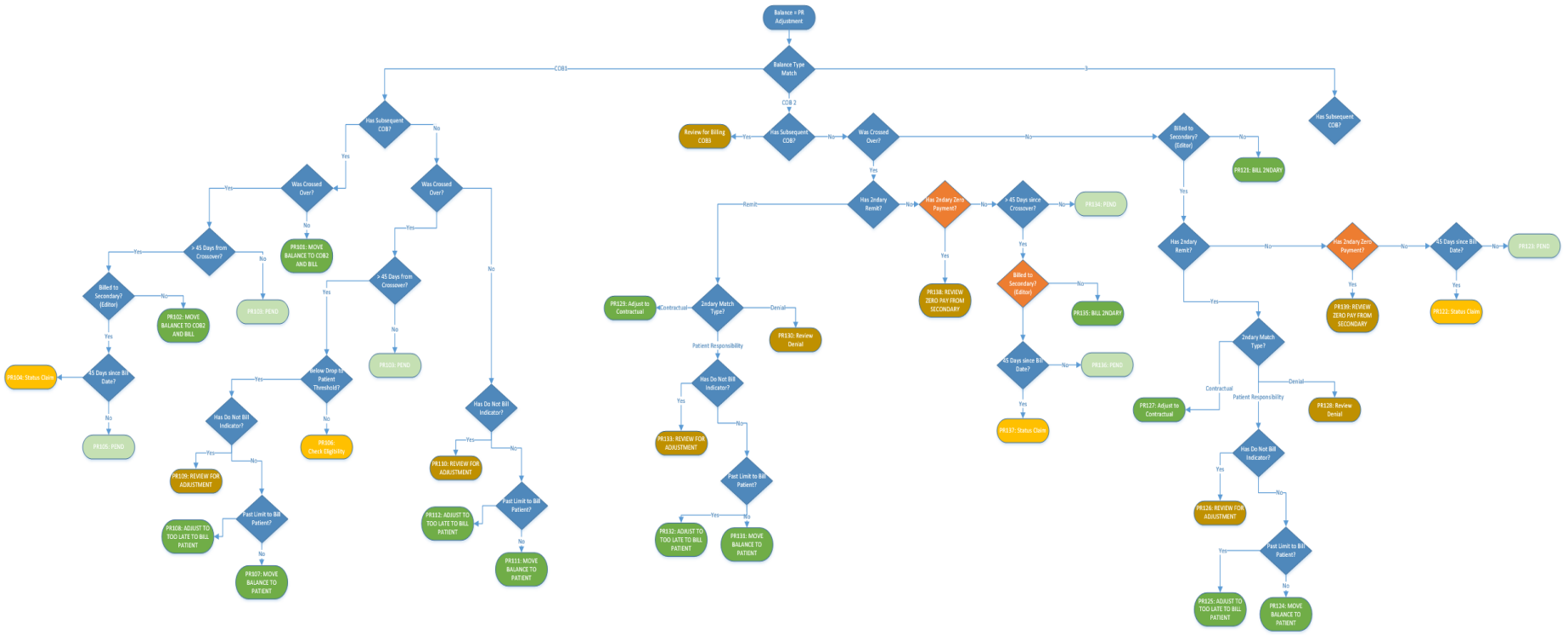
AND

No Patient Bill or Payment on Account

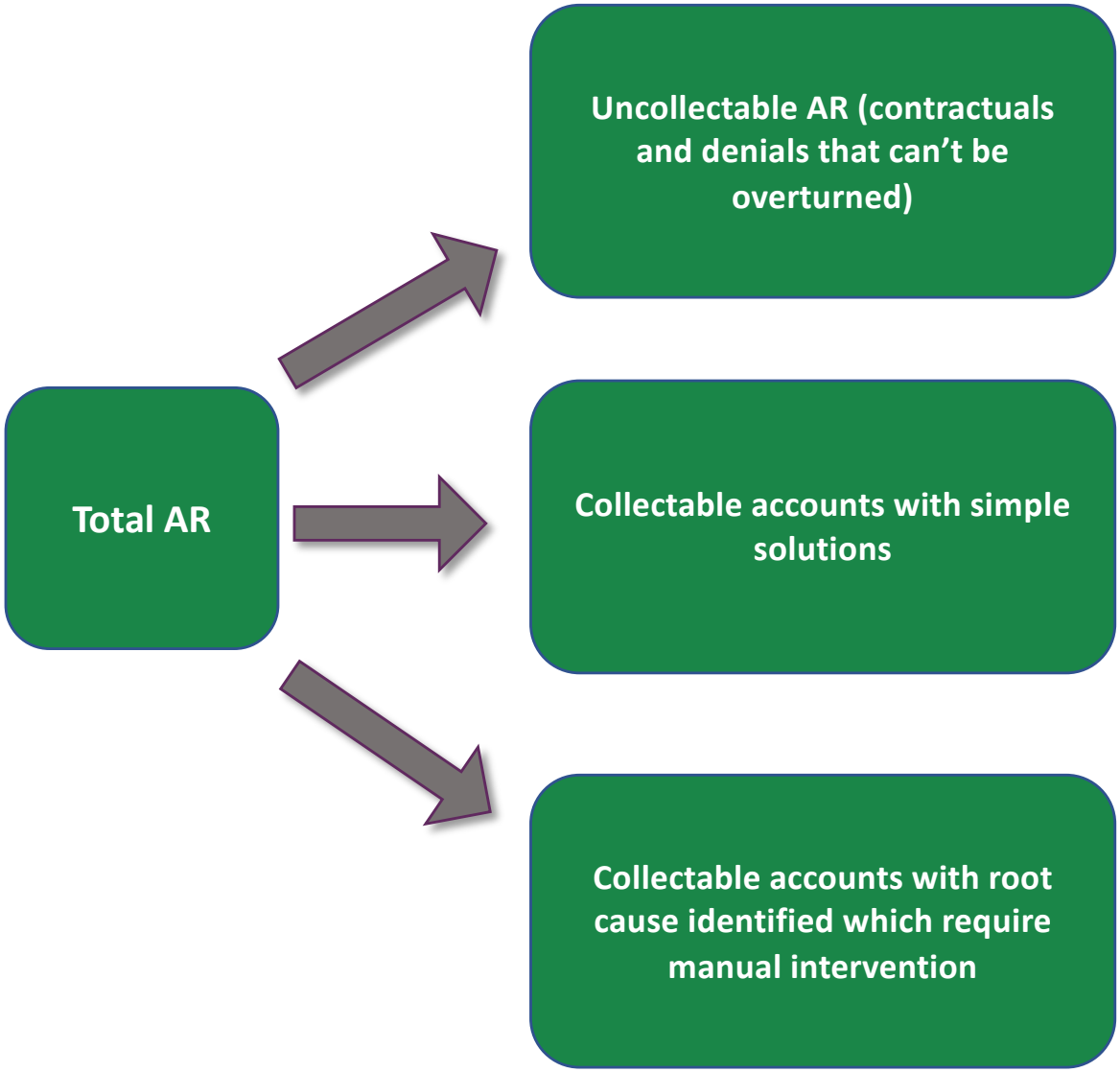
Correlate what is known about a claim to draw conclusions about defects and next steps

Systematize Staff Decisions

Evaluate each account for: collectability, root cause defect, timing of next follow up, next required action



Root Cause Analysis

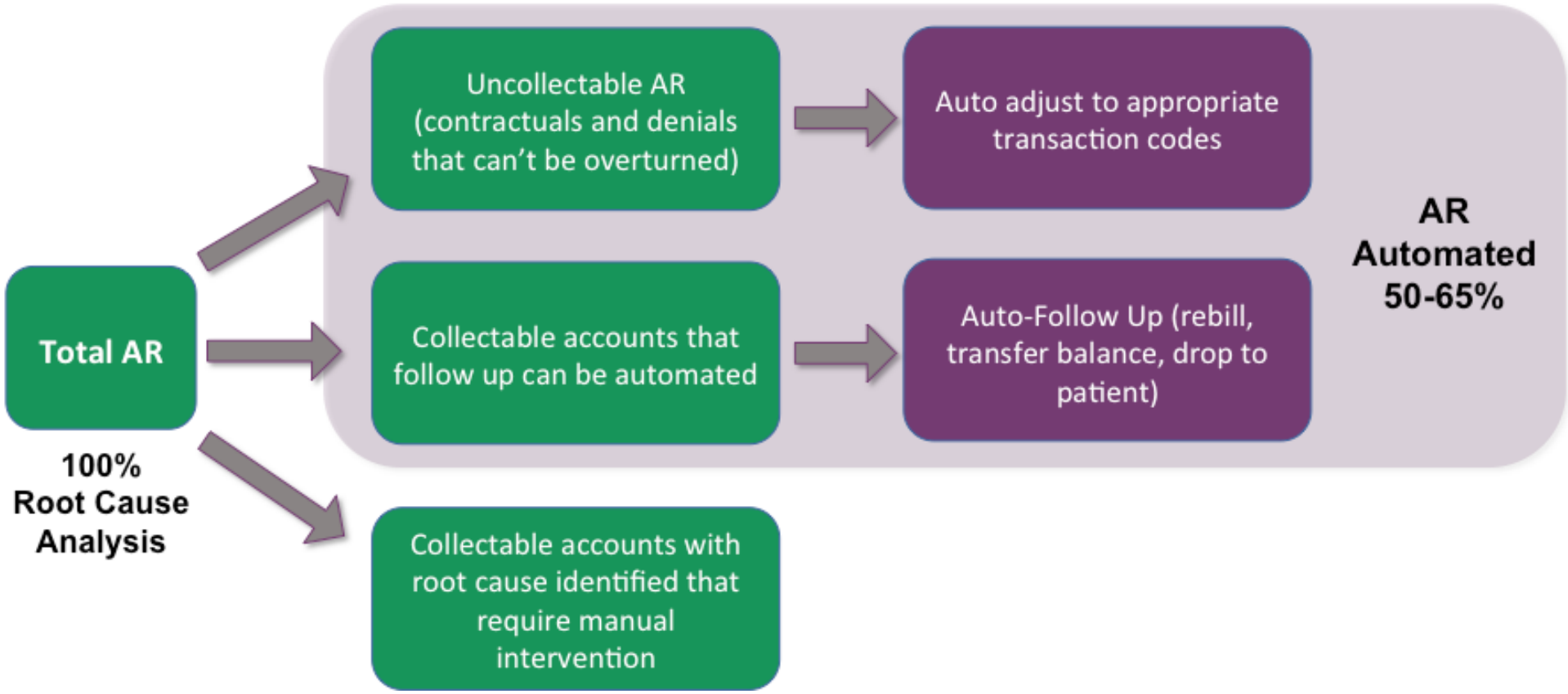


40%

25%

35%

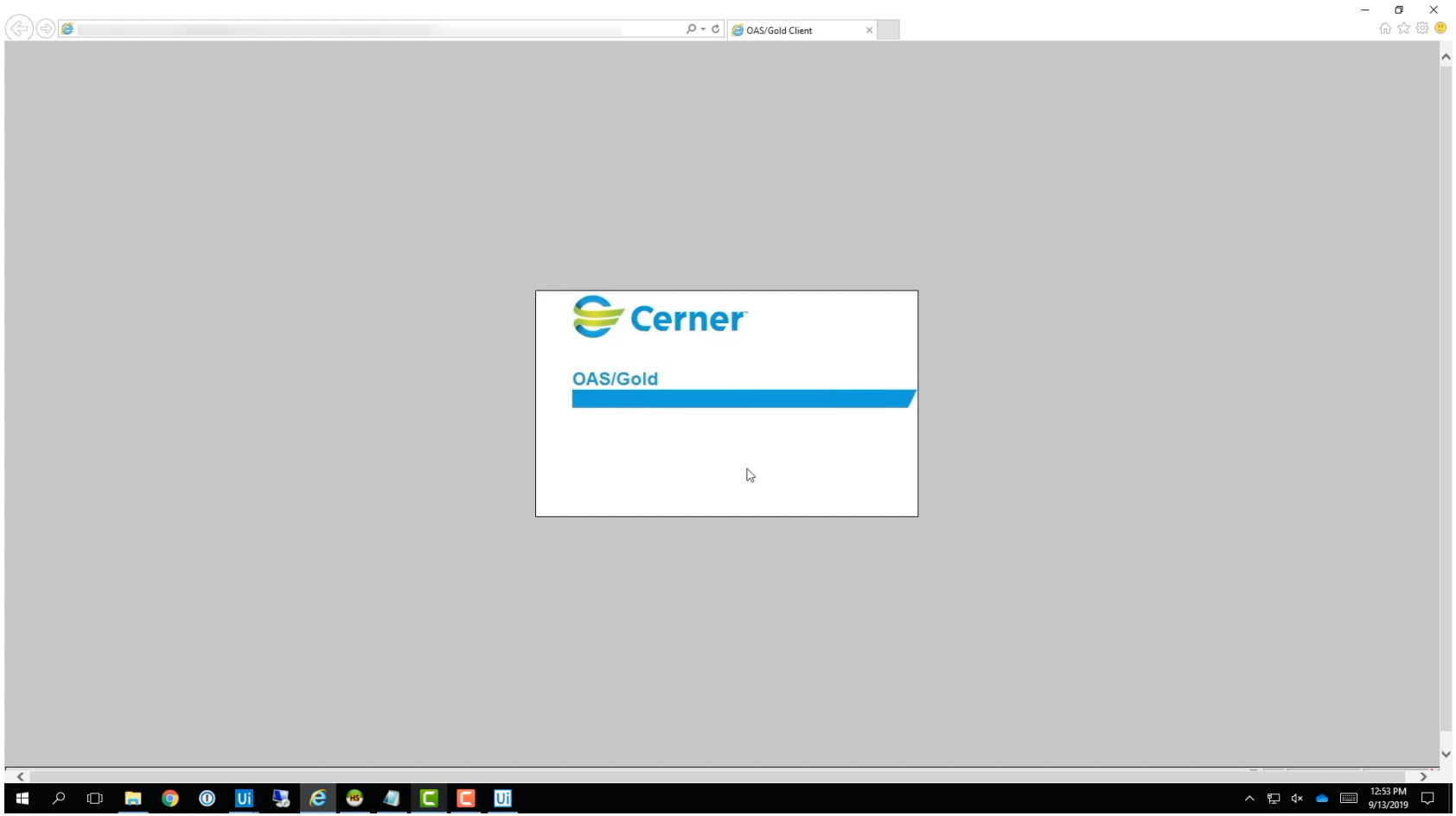
Automate Simple Tasks



Turn decisions into action through RPA

RPA is software that is “trained” to replicate the actions of a human user

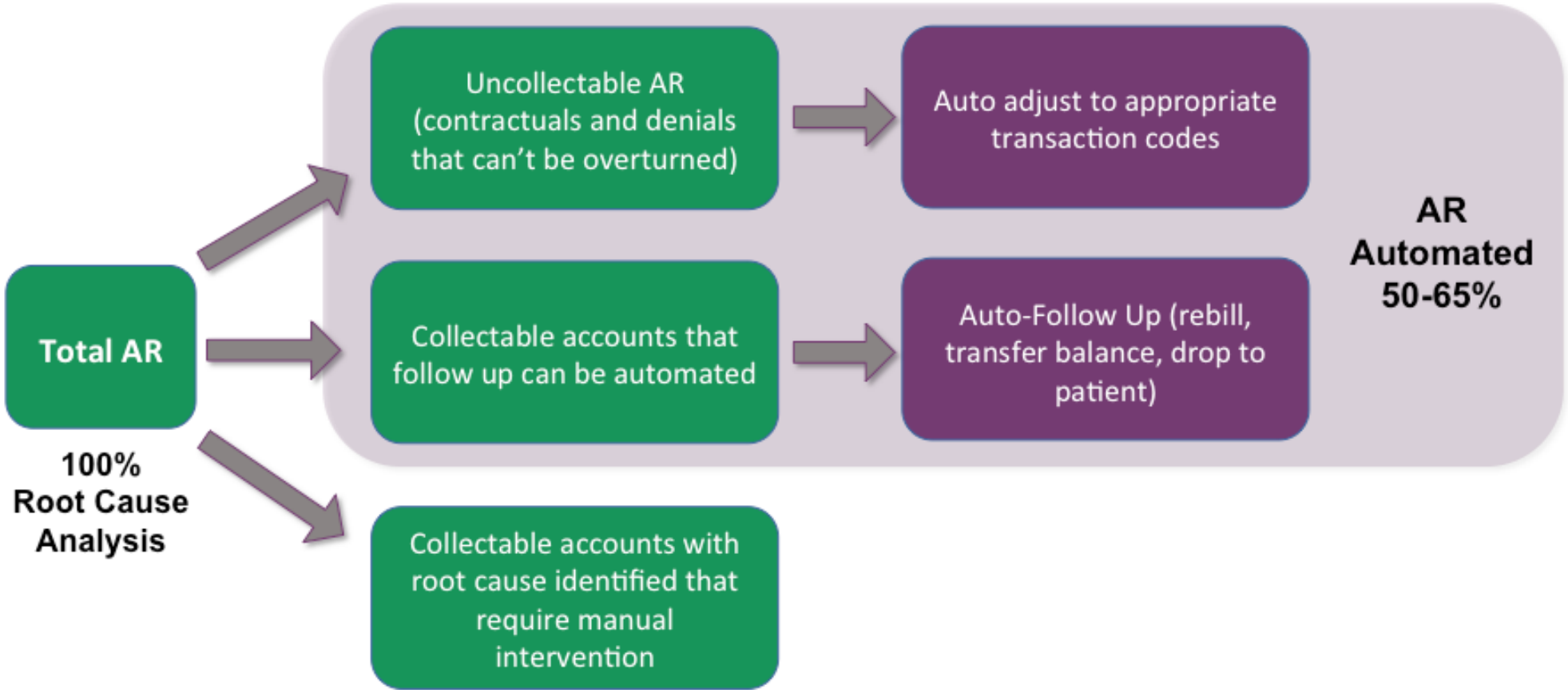
RPA Application



Challenges of RPA

- Some expertise required – need a business analyst or similar resource
- Need to test thoroughly – performing thousands of the WRONG transaction is a problem
- Need volume – automating a small number of claims may not be worth it

Give Staff Direction



Manual Intervention

Distribute and sequence to users for efficient follow up with prescribed next action

25% identify next step

- Minimize research
- Intelligent Sequencing of claims

10% Unknown

Post Analytics Follow Up

Type of Action	Type of Account	Volume	Time Allocation	Action	Research
				0.0%	0.0%
Automated	Non-Collectable	40%		**0.0%**	**0.0%**
Automated	Simple Claims	25%		0.0%	**0.0%**
				80.00%	20.00%
Manual	Analytic Suggestions	25%	71%	57.1%	**14.3%**
				40.0%	60.0%
Manual	Complex Claims	10%	29%	11.4%	**17.1%**

No Value	**31.4%**
High Value	68.6%

Case Study

Example from a $250m AMC categorized low balances (>60 days, <$2500) into 160 different categories – these are the top categories

Category	count(AccountNumber)	sum(AccountBalance)	% of All Volume	Pursue?
Payment made but no remit	2860	$ 1,368,342	17%	N
Activity not Timely Within Filing and Appeal Limits	1886	$ 868,225	11%	N
Late Charge not equal to balance	1701	$ 1,129,869	10%	Y
Unknown Balance $25 to $250	1674	$ 235,171	10%	Y
No Record of Sent Claim	1295	$ 845,572	8%	Y
Unknown Balance$250 to $500	1110	$ 368,095	7%	Y
Balance moved to 2ndary but not billed	972	$ 347,075	6%	Y
Unknown Balance $500 to $1500	966	$ 833,520	6%	Y
Late Charge equals balance	454	$ 180,863	3%	N
No payments posted but remit available	380	$ 268,336	2%	Y
NonCovered Denial Equals COB1 Balance	325	$ 197,190	2%	Y

65% viable, 35% dead

Example Outcomes

35% with no collection opportunity

Category	count(AccountNumber)	sum(AccountBalance)	% of All Volume	Pursue?
Activity not Timely Within Filing and Appeal Limits	1886	$ 868,225	11%	N

By reviewing billing and appeal activity relative to filing and appeal limits, we determined that these claims had exceeded the payer limits.

Category	count(AccountNumber)	sum(AccountBalance)	% of All Volume	Pursue?
Late Charge equals balance	454	$ 180,863	3%	N

By comparing bill and charge dates, we can identify Late Charges. Where Late Charges are equal to the balance on the claim, there is no collection opportunity.

Category	count(AccountNumber)	sum(AccountBalance)	% of All Volume	Pursue?
Unposted Contractual Equals COB1 Balance	58	$ 53,935	0%	N

Had this contractual been posted accurately, it would have reduced the balance to zero

Example Outcomes

65% with potential collection opportunity

Category	count(AccountNumber)	sum(AccountBalance)	% of All Volume	Pursue?
No Record of Sent Claim	1295	$ 845,572	8%	Y

For a variety of reasons, claim did not leave the system – needs to be billed

Category	count(AccountNumber)	sum(AccountBalance)	% of All Volume	Pursue?
Balance moved to 2ndary but not billed	972	$ 347,075	6%	Y

Balance was moved to next payer, but never billed – needs to be rebilled

Category	count(AccountNumber)	sum(AccountBalance)	% of All Volume	Pursue?
Eligibility Denial Equals COB1 Balance	120	$ 106,309	1%	Y

Denied balance has not been worked – eligibility should be checked (preferably in batch mode) and billed appropriately

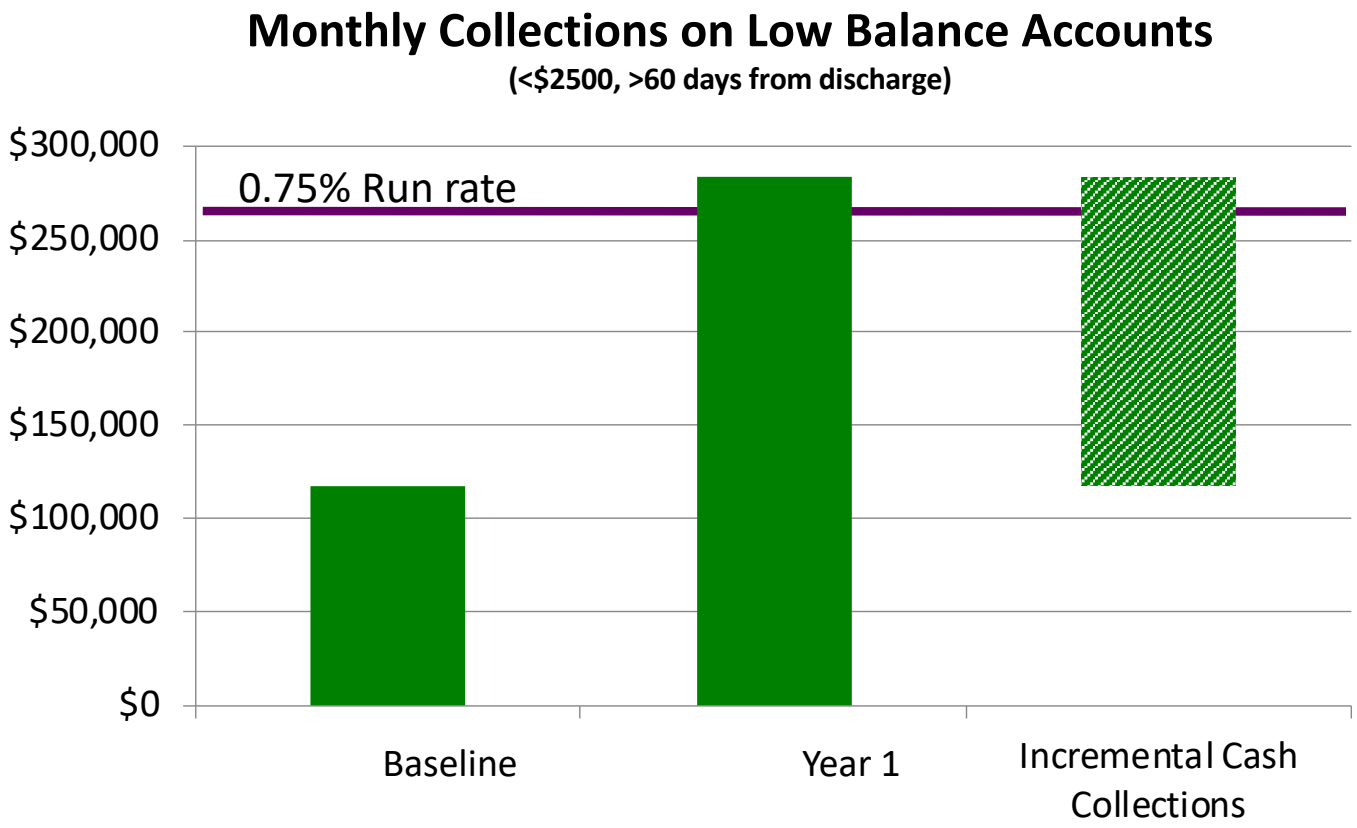
Category	count(AccountNumber)	sum(AccountBalance)	% of All Volume	Pursue?
Pt Responsibility Equals COB1 Balance	87	$ 30,719	1%	Y

Remit indicated balance is patient responsibility, but balance has not been moved to patient

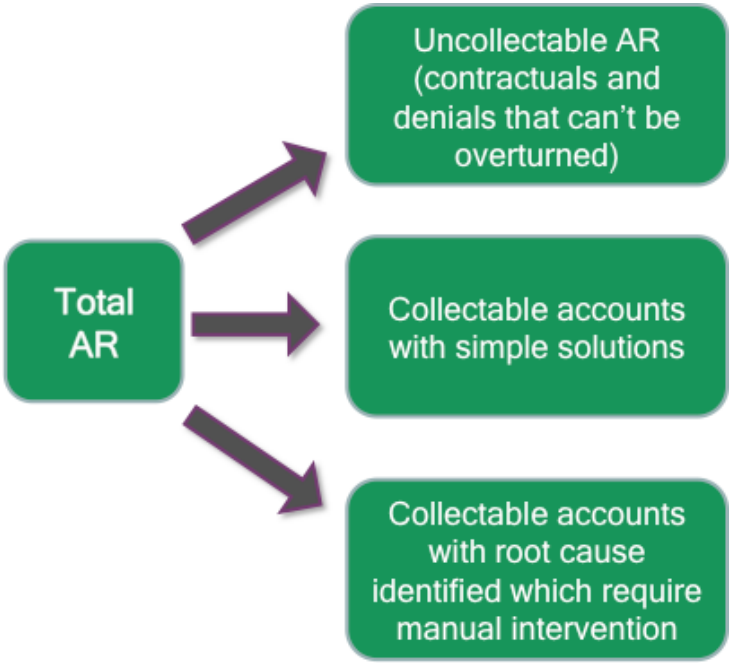
Case Study: Results

A focus on low balance claims leads to incremental collections that were previously written off or otherwise lost to the organization

.75% of NPR in *annual incremental* cash collections



Analytics and RPA benefits



- No Coin flip
- No Human Error
- Detailed insight on every claim

Allows for systemic decision making – managerial choices about how to work each claim category

Outcomes

- Staff time moved from non-value add activities to value add activities
- 65% of AR resolved through automation
- 25% of AR expedited through follow up insight
- 400% productivity improvement

Incremental Collections, Accelerated Collections, and Reduced AR

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Suggested Strategies

1. DELIBERATELY ALLOCATE RESOURCES

The proportional value of small balance accounts to the amount of AR dollars associated makes it critical to ensure you do not sacrifice the collections opportunity on your high dollar accounts in order to work the large volume of low balance accounts.

Recognize the value in collection of your low balance accounts, and adopt an intelligent, organized approach to their collection

Suggested Strategies

2. IDENTIFY "DEADWOOD."

Older accounts may exceed contractual timely filing and appeals limits. However, these accounts may still be collectable, so it requires you to be diligent in your analysis.

Analysis of your uncollected low balance claims will divide those accounts between two buckets: "deadwood" (uncollectable claims) and those with collection opportunities

Suggested Strategies

3. WORK "BY ISSUE"

By working "issues" -- rather than accounts -- you will see more efficiencies. Spending time analyzing your receivables in order to string accounts together that have the same issue is faster than individually troubleshooting accounts one-by-one-by-one.

Additionally, root cause analysis and pattern identification will identify upstream process failures

Suggested Strategies

4. FIX UPSTREAM PROCESSES

A focus on the small volume of high dollar accounts can identify acute – though generally isolated – problems. By focusing on the high volume of low dollar accounts systematic, process-driven issues are revealed. Prevent future cleanup projects by taking action today to resolve upstream errors.

Mining the data and collecting feedback on low dollar projects generally highlights processes that require attention, such as insurance verifications, authorizations, billing edits, payer processing issues, etc

Suggested Strategies

5. LEVERAGE AUTOMATION TO YOUR ADVANTAGE

Modern automation tools are an increasingly common way to let technology process large volumes of claims. Establishing a more efficient process takes some effort, time and expertise, but has significant long term benefits in terms of efficiency and collection.

Systems that institute a tool which automates both the analysis and collection of low balance accounts can see an increased collection of 1% Net Revenue

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Conclusions

- An ROI focus has unintentionally created an environment where low dollar claims are neglected
  - Low Balances constitute 4% of dollars, but 85% of volume
- Our research has led to two clear conclusions:
  - First, up to 1% of net revenue is trapped in Low Balances
  - Second, providers can see a positive ROI working claims down to a shockingly low value -- $35-$100
- Better analytics enables automation and more consistent collections
- Providing better insight leads to more efficient AR management and therefore lower AR, incremental cash, etc.

Questions?

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