nThrive

Avoid Costly Write-Offs and Manage the Complex Task of Provider Enrollment

HFMA SC // June 1, 2018

AGENDA

Industry insight: How we got here

Common problems

Effects across the revenue cycle

Fast-track credentialing

Driving Results

Account monitoring

KPIs

Q+A

INDUSTRY INSIGHT

How we got here

Ranked **best in KLAS for revenue cycle** outsourcing 2015/2016

30 years of industry experience

$1 billion claims processed per day

$400 billion patient revenue touches

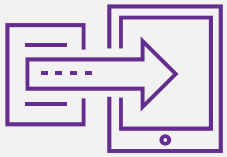
Dedicated A/R colleagues assigned with an average of **12 years of experience** working in hospital and physician settings

20 average years of revenue cycle experience of the management team

Comprehensive reporting package

Only vendor selected to participate with the AHA / HFMA to develop Patient Financial Interactions Best Practices recommendations

INDUSTRY INSIGHTS
How we got here

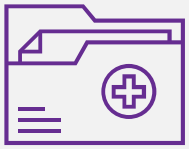


Rise of Uncompensated Care

Burdens patients, hospitals, and state budgets

Decline of Medicaid Payments – Waivers

Recent proposed or approved waivers to take Medicaid away from people not working or locking people out of coverage



Affordable Care Act

ACA provider enrollment fee to Medicaid is increased to more than $500 for CY2018

Overtaxed Staff Resources

Staff are focused on patient care and reimbursement activities, and may not have the training or program-specific knowledge for enrollment

Margin Pressure

Health systems must find new ways to decrease costs, as private payors and employers can no longer absorb shifted costs.

Strategies includes lowering cost to collect and bad debt write offs, and increasing cash collections.

Common Client Problems

Don’t know **HOW** to enroll

State-specific guidelines are confusing or overwhelming

Don’t have **TIME** to enroll

Staff to support enrollment efforts are busy with other tasks they perceive as closer to revenue line

Enrollment too **LATE**

Lost revenue when enrollment timelines are missed due to incompletion or lateness

Effects Across the Revenue Cycle

Enrollment Affect Multiple Areas

Scheduling

- Benefit plan coverage
- Benefit maximums exceeded
- Eligibility
- Experimental procedure
- Authorization
- Pre-existing condition
- Medical necessity
- **Credentialing**

Access

- **Benefit plan coverage**
- Benefit maximums exceeded
- Coordination of benefits
- **Eligibility**
- Experimental procedure
- **Authorization**
- Pre-existing condition
- Medical necessity
- Documentation

Patient Care

- Medical necessity
- **Authorization**
- Experimental procedure
- Documentation

HIM, Charge Capture

- Documentation
- Medical necessity
- Experimental procedure
- **Authorization**
- Benefit plan coverage
- Coding

Billing/Collection

- Bundling
- Coding
- Demographic mismatch
- Documentation
- **Eligibility**
- **Authorization**
- Pre-existing conditions
- Timely filing
- Coordination of benefits

Fast-Track Provider Enrollment

The more competitive the market becomes,
the more providers must decrease bad debt and the cost to collect.

EXPERT RESOURCES

Acquire talent with future capabilities and roles in mind. Focus on quality over quantity and ensure staff shares core values.

PERFORMANCE SUPPORTED BY TECHNOLOGY

Track KPIs closely to ensure performance is aligned with programmatic effort. Manage accounts to optimize revenue.

DATA-DRIVEN PROCESS

Leverage effective data and reporting to monitor performance and facilitate informed decision-making. Collect and analyze data and review it regularly to identify process issues and opportunities for improvement.

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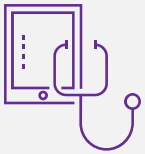
Drive Results with Minimum Investment

TARGET PLANNING

Average Medicaid volumes from all 52 states and territories



RAPID ENROLLMENT

Streamline enrollment by grouping documents by state and program

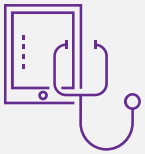
CREDENTIAL COMPLIANCE

Ensure you are meeting the needs of each state provider's credentialing requirements

Drive Results with Minimum Investment

PROMPT BILLING

Prepare and submit claims to out-of-state Medicaid offices, and follow up on claims to maximize payment amounts and reduce cash cycle time



CRITICAL FOLLOW-UP

Monitor accounts for payments and initiate appeals on denied claims as warranted

QUALITY REPORTING

Recap status of all out-of-state Medicaid accounts and provide DSH calculations

Expert Resources

- Ensure your clinical staff and eligibility specialists are experts at obtaining Medicaid authorization for services
- Ensure accurate and timely submission to Medicaid
- Hire educated/trained staff
- Dedicate project supervisors
- Know out-of-state protocols inside and out

Addresses Business Issues:

- ✓ Timely and accurate submission to Medicaid
- ✓ Subject matter expertise
- ✓ State-specific knowledge

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Performance Supported by Technology

- Leverage account resolution software to ensure process optimization
- Analyze data to assist in creating propensity-to-pay algorithms – formulas used to differentiate level of effort between accounts to align resources to likelihood of revenue
- Look for custom reporting and program parameters to provide timely, insightful response to client requests

Addresses Business Issues:

- ✓ Technology enablement
- ✓ Visibility into data
- ✓ Insight-driven decision making

Data-Driven Process

- Share data on account balances, notes, and collection efforts regularly with leadership
- Reclass accounts by payor to allow for focused collection efforts
- Prioritize workflow based on goals and assign accounts accordingly. Focus on larger dollar claims to drive maximum cash collections.
- Follow up with a standard process to check for data accuracy, duplicate placements, and reconciliation

Addresses Business Issues:

- ✓ Cash collections
- ✓ Workflow prioritization
- ✓ Process improvement

State Enrollment Challenges

State-specific enrollment challenges further detract hospitals.

CALIFORNIA

Needs per facility:

Managing Control Information, IRS letter

Corporate Board of Directors personal details including drivers license or state issued ID.

License Certificate, CLIA Certificate, DEA certificate, Liability insurance, 3 documents with public notary:

1) Medi-cal Provider Agreement
2) Medi-cal Disclosure Statement
3) Electronic Fund Transfer

Authorization Bank letter

KENTUCKY

Needs per facility:

Attach appropriate licenses and /or certifications and all other required documents for requested effective date

Verification documentation for NPI and Taxonomy Code(s) from CMS NPI vendor or NPPES

IRS verification letter if applying with a FEIN

First and Last name of the person to sigh for a summons in case of a lawsuit

Corporate Board of Directors personal details Hand-signed and dated signature page – Electronic or stamped signatures are not accepted.

Any application line left blank results in immediate rejection

MICHIGAN

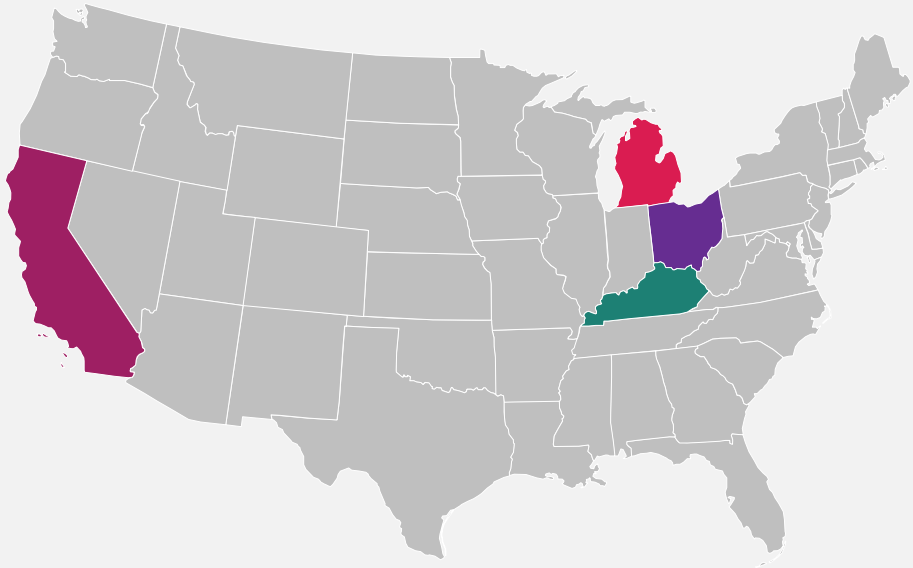
Needs per facility:

Facility information including Locations - Services, Correspondence, and Pay to address, specialties, EDI exchange information, Provider Controlling Interest/Ownership Details – Facility, Managing employee personal details, One board member personal details, Taxonomy details, modification list

OHIO

Needs per facility:

Signed Provider Agreement, tax forms, copy of NPPES letter, copy of all licenses, certificates, or accreditations as reported in the application, copy of the Medicare certification letter, copy of CLIA certificate



Key benefits of a best-practice out-of-state Medicaid program

HEALTH SYSTEM BENEFIT

Increased reimbursement

Increased cash flow

Reduction in bad debt

Reduction in uncompensated care

Higher patient satisfaction scores

PATIENT BENEFIT

Greater access to providers

Coverage for hospital services and follow-up care

Decrease in out-of-pocket expenses

A positive patient experience

How do you measure up?

Key performance indicators of a
high-performing out-of-state Medicaid program

10%
CASH RECOVERY

85-90%
ACCOUNT RESOLUTION

100%
PROVIDER ENROLLMENT IN ALL 50+ STATES

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Sample of Client Results

SPEED-TO-VALUE

Confidential Client

By developing customized issue-based reporting, **nThrive led the client to reduce preventable denials and unnecessary A/R aging by more than $1M per month within four months of project go-live.** By illustrating key trends in aging with simple remedies and prevention efforts, the client improved their bottom line by millions of dollars.

100% ACCOUNT RESOLUTION

Confidential Client, Texas

nThrive took on legacy system AR accounts aged over 151 days (an average age of 418 days) and resolved the entire inventory of more than 50,000 accounts within the first 12 months, freeing up the system's team to focus on new business, including a PAS conversion.

REDUCTION IN UNCOMPENSATED CARE

Large Voluntary Nonprofit Healthcare System, Virginia

nThrive generated over **$7M in revenue** in 2017. The healthcare system saw a **decrease in unreimbursed Medicaid costs year over year along with a reduction in uncompensated care**.

Key Takeways: Steps to Address Enrollment Challenges

- Know each payer's requirements and track
- Submit complete, current, and accurate information
- Start enrollment process sooner rather than later
  - Where are you collection the information in the process?
- Use online capabilities if available

Key Takeways: Steps to Address Enrollment Challenges

- Communicate in a timely manner
  - You can’t overcommunicate in this space
- Consider partnering with physician recruitment team for further internal efficiency
- Work with a vendor
- Integrate MSSD (Medical Staff Services Department) and Provider Enrollment Teams

Questions

THANK YOU