



What is the Health Care Credit Worth?

Health Care Credit: Full Credit available for employers with less than 10 employees earning less than \$25K annually

Phase out complete at 25 employees earning \$50K annually

Real example

| | | | | | |
|--|----------|----------|------------|-------------|----------|
| Full Time Equivalent Employees | 5 | 10 | 12 | 25 | 12 |
| Total Payroll | 75,000 | 250,000 | 360,000 | 750,000 | 181,657 |
| Average Annual Full Time Equivalent Wage | 15,000 | 25,000 | 30,000 | 30,000 | 15,138 |
| *Employer Provided Health Care Costs (\$2,500/EE) | 12,500 | 25,000 | 30,000 | 62,500 | 3,071 |
| Credit (35% 2010 - 2013**) | 35% | 35% | 35% | 35% | 35% |
| Tax Credit | \$ 4,375 | \$ 8,750 | \$ 10,500 | \$ 21,875 | \$ 1,075 |
| Credit Reduction for Excess Employees over 10 (X/15) | | | \$ (1,400) | \$ (21,875) | \$ (143) |
| Credit Reduction for Excess Wages (X/\$25,000) | | | \$ (2,100) | \$ (4,375) | \$ - |
| Total Tax Credit ~ | \$ 4,375 | \$ 8,750 | \$ 7,000 | \$ - | \$ 932 |



Health Coverage or Penalty - Which is more economical?

Individuals

Greater of a) flat dollar amount or b) a percentage of your household income

Flat Dollar Penalty reduced by 50% for children

Penalty capped at three times the adult fine per year or 8 children

| Tax Year | | 2014 | | 2015 | | 2016 |
|--------------------|----|--------|----|--------|----|--------|
| Flat Dollar | \$ | 95 | \$ | 325 | \$ | 695 |
| Percentage | | 1% | | 2% | | 2.5% |
| Adults in Family | | 2 | | 2 | | 2 |
| Children in Family | | 4 | | 4 | | 4 |
| AGI | \$ | 50,000 | \$ | 50,000 | \$ | 50,000 |
| Flat Dollar | \$ | 380 | \$ | 1,300 | \$ | 2,780 |
| % of AGI | \$ | 500 | \$ | 1,000 | \$ | 1,250 |
| Actual Penalty | \$ | 500 | \$ | 1,300 | \$ | 2,780 |

Business Penalty

Applies to those with more than 50 employees

\$2,000 credit for each employee over 30

| | | | | | | |
|--------------------------------|----|---------|----|---------|----|---------|
| Full Time Equivalent Employees | | 55 | | 75 | | 100 |
| Less first 30 Employees | | -30 | | -30 | | -30 |
| Total | | 25 | | 45 | | 70 |
| Penalty | \$ | 50,000 | \$ | 90,000 | \$ | 140,000 |
| Cost of Health Coverage* | \$ | 137,500 | \$ | 187,500 | \$ | 250,000 |

*\$2,500 per employee used for this example



Medicare Tax Increases
Beginning 2013 apply to
Wages in excess of \$200K Single or \$250K MFJ &
Less of Net Investment Income or MAGI in excess of limits

Example: Qualified Manufacturer, MFJ no dependents

| | | Wage Surcharge 0.9% | Net Investment Income 3.8% |
|---|---------------|---------------------------|----------------------------------|
| Wages | 96,800 | - | |
| Interest | 61 | | 61 |
| Dividends | 2,205 | | 2,205 |
| Taxable Refund | 1,345 | | 1,345 |
| Capital Gains | 208,058 | | 208,058 |
| Non Passive S Corp | 634,873 | | |
| Passive Rental Real Estate | 137,802 | | 137,802 |
| Miscellaneous Investment | 263 | | 263 |
| Domestic Production Deduction | (35,169) | | |
| Adjusted Gross Income | 1,046,238 | 0 | 349,734 |
| MAGI Excess of \$250,000 | 796,238 | | |
| Tax | | 0 | 13,290 |
| Total Additional Tax | | \$ | 13,290 |
| Wages not in excess of \$250,000 no wage surtax | | | |
| Net Investment Income less than MAGI Excess | | | |



Medicare Tax Increases
Beginning 2013 apply to
Wages in excess of \$200K Single or \$250K MFJ &
Less of Net Investment Income or MAGI in excess of limits

Example: Physician, MFJ, 2 dependents

| | | Wage Surcharge | Net Investment Income |
|------------------------------------|---------------------|--|----------------------------------|
| | | 0.9% | 3.8% |
| Wages | 424,867 | 424,867 | |
| Interest | 248 | | 248 |
| Taxable Refund | 1,208 | | 1,208 |
| Passive Surgery Center Partnership | 57,153 | | 57,153 |
| Family Partnership | 1,760 | | |
| | | | |
| Adjusted Gross Income | <hr/> 485,236 <hr/> | <hr/> 424,867 <hr/> | <hr/> 58,609 <hr/> |
| | | | |
| MAGI in excess of \$250,000 | 235,236 | 174,867 | |
| | | | |
| Tax | <hr/> 104,095 <hr/> | <hr/> 1,574 <hr/> | <hr/> 2,227 <hr/> |
| | | | |
| | | Total Additional Tax | \$ 3,801 |
| | | Wages in excess of \$250,000 taxed at .9% | |
| | | Net Investment income lower than excess MAGI | |



Healthcare Reform 2010

This notice addresses the Patient Protection and Affordable Care Act of 2009 (PPACA) as modified by the Health Care and Education Reconciliation Act of 2010 (HCERA). Some of the actual implementation timelines and exact rules remain unclear, but we will keep you informed as things progress. We have tried to summarize the law but, of course, there could certainly be modifications prior to the proposed implementation dates.

What does this mean to me as an employer right now?

If you have less than 25 Full-Time Equivalent Employees:

1. If you have less than 25 full-time equivalent employees and your average wage is less than \$50,000, you may be eligible for a maximum tax credit retroactive to 1/1/10, of up to 50% of your premiums for up to 2 years, if you contribute at least 50% of the total premium cost.
2. If you have 10 or less full-time equivalent employees and your average employee wage is less than \$25,000, you will be eligible for the maximum credit.
3. The credit will be phased in beginning at 35% and is retroactive to 1/1/2010.

All fully-insured medical plans, regardless of size: (the following provisions will be effective for plan years renewing October 1, 2010 or later)

1. You will be subject to all of the non-discrimination rules under IRC Section 105 (h) that currently apply only to self-insured health plans. **
2. Lifetime limits on group and individual plans will be prohibited.
3. Annual limits will not be allowed on essential benefits. This provision applies to self-funded plans as well. The Secretary of HHS shall define essential benefits, but they must at least include the following:
 - a. Ambulatory patient services
 - b. Emergency services
 - c. Hospitalization
 - d. Maternity and newborn care
 - e. Mental health and substance use disorder services, including behavioral health treatment
 - f. Prescription drugs

- g. Rehabilitative and habilitative services and devices
 - h. Laboratory services
 - i. Preventive and wellness services and chronic disease management
 - j. Pediatric services, including oral and vision care
4. All group and individual plans will have to cover dependents, married or not, up to their 26th birthday unless that dependent is eligible for their own employer-sponsored plan, (the group health plan tax exclusion has been extended to those dependents under new IRS rules). This provision applies to self-funded plans as well. New notices of the “special enrollment” opportunity must be given to all employees covered under your group plan.**
 5. Rescission of health coverage will be prohibited except for fraud or intentional misrepresentation. This provision applies to self-funded plans as well.
 6. Emergency services will be covered as in-network regardless of the provider.
 7. Enrollees may designate any in-network doctor as their primary care physician. **
 8. Coverage for specific preventive services on a first dollar basis (no deductible, no co-pay and no co-insurance). **
 9. Secretary of HHS will have new authority to monitor health insurance carrier premium increases to prevent unreasonable increases, and publicly disclose such information.

Additionally:

1. A high-risk pool will be created for people who cannot obtain current individual coverage due to pre-existing coverage. Over thirty states (Colorado included) already have such a pool. This pool will operate in addition to Colorado’s current pool (Cover Colorado) and will expire on 12/31/2013 when Exchanges become operational and pre-existing condition limitations are totally removed.
2. A 10% excise tax will be imposed on indoor tanning services.

Grandfathering: What’s the big deal?

1. Continue to discriminate by class with regards to waiting periods and contributions and eligibility.
2. Not have to move to the 3:1 rating ratio in 2014.

BUT, rules for maintaining that status are very difficult to comply with. Each company must decide if it’s worth it.

What does this mean to me as an employer in 2011?

All fully-insured medical plans, regardless of size:

1. The penalty tax on distributions from a Health Savings Account (HSA) that are not used for qualified medical expenses increases from 10% to 20%.
2. Over-the-counter drugs will no longer be reimbursable under HSAs, FSAs, HRAs or Archer MSAs, unless prescribed by a doctor, with the exception of insulin.
3. Small employers will be allowed to adopt new “simple cafeteria plans”.
4. A federal grant program for small employers providing wellness programs to their employees takes effect.
5. Minimum loss ratio (MLR) requirements will be established for insurers in all markets. (Whether it applies to self-funded plans is uncertain). For a large group (101 employees or more) it will be 85%, and for small group and individual policies, 80%. In general, the MLR is the percentage of premiums collected that must be paid out in claims. Specifically, what will be included in the “claims” category is unclear at this time.

Additionally:

1. A new public long-term care program (Community Living Assistance Services and Supports Act – CLASS) is created and requires all employers to enroll employees, unless the employee elects to opt out.

What does this mean to me as an employer in 2012?

All group plans, fully-insured or self-insured:

1. Will have to provide a summary of benefits and a coverage explanation that meets specified criteria to all enrollees including: when they apply for coverage, when they enroll or re-enroll in coverage, when the policy is delivered and identify when any material modification is made to the terms of their coverage.
2. The summary and explanation can be provided electronically or in written form, and there is a \$1,000 per enrollee fine for willful failure to provide the information.
3. All employers must include on the W-2s issued for the 2012 tax year, the aggregate cost of employer-sponsored health plans.
4. 1099s for all purchases in excess of \$600.

What does this mean to me as an employer in 2013?

All group plans, fully-insured or self-insured:

1. An additional .9% Medicare Hospital Insurance tax on self-employed individuals and employees with earnings and wages during the year of \$200,000 for individuals and \$250,000 for joint filers.
2. Self-employed individuals are not permitted to deduct any portion of the additional tax.
3. Notice must be provided to employees regarding Exchanges

Additionally:

1. A new 3.8% Medicare contribution on certain unearned income from individuals with Adjusted Gross Income (AGI) over \$200,000 for individuals or \$250,000 for joint filers.
2. The threshold for the itemized deduction for unreimbursed medical expenses would be increased from 7.5% of AGI to 10% of AGI for regular tax purposes.
3. New annual fees will be imposed on medical device manufacturers and importers. The tax does not apply to eyeglasses, contact lenses, hearing aids and any other device deemed by the Secretary of HHS to be of the type available for regular retail purposes.
4. FSAs will now have a maximum plan year contribution limit of \$2,500 with the cap indexed for inflation.

What does this mean to me as an employer in 2014?

All group plans, fully-insured or self-insured:

1. Coverage must be offered on a guarantee issue basis in all markets and be guaranteed renewable.
2. Exclusions based on pre-existing conditions will be prohibited in all markets.
3. Full prohibition on any annual limits or lifetime limits in all group and or individual plans.
4. All individual health insurance policies and all fully-insured group policies with 100 lives or under (and larger groups purchasing their coverage through the exchanges) must abide by strict modified community rating standards with premium variations only allowed for age (3:1), tobacco usage (1.5:1), family composition and geographic regions to be defined by the states and experience rating would be prohibited.**
5. Wellness discounts are allowed for group plans under specific circumstances.
6. Redefines small group coverage as 1-100 employees.
7. Employers don't have to offer health insurance coverage, **but** if they employ more than 50 Full-Time-Equivalent employees (FTEs), they must pay a fine per employee per year (\$2,000) for each full-time employee they **don't** cover after subtracting the first 30 full-time employees. The

coverage can't be just any coverage and must meet the "essential benefits" requirements in order to be compliant.

8. Catastrophic-only policies will be allowed only to those who are 30 or younger.
9. An employer with more than 50 FTEs is required to have no longer than a 90 day waiting period before an employee can enroll in health care coverage. If their waiting period is longer than that, they will pay a \$600 fine for each employee subject to the longer waiting period.
10. Employers of 200 or more employees will be required to auto-enroll all new employees into any available employer-sponsored health insurance plan.
11. All health plans must provide coverage documentation to both covered individuals and the IRS.

Additionally:

1. All American citizens and legal residents will be required to purchase qualified health insurance coverage. Some exceptions apply and subsidies will be available for certain situations.
2. Penalties will apply for those who do not comply.
3. Each state will be required to create an Exchange to facilitate the sale of qualified benefit plans to individuals and small employers.

What does this mean to me as an employer in 2018?

For all fully-insured or self-insured medical plans:

1. 40% excise tax on "Cadillac plans" with values exceeding certain dollar amounts. Certain high-cost states would receive transition relief.

** A grandfathered plan is an individual or group plan that was in existence on March 23, 2010 and made no changes to the plan except to enroll and unenroll employees. A grandfathered plan does not have to comply with certain provisions of the law as long as the plan retains its status.

Wars and Rumors of Wars

What are the rumors, what might change?

- November 2, 2010
- November 6, 2012
- CLASS Act moving to 1/1/13
- 1099 reporting changes being rescinded
- Medical Loss Ratio (MLR) guidelines being postponed
- Grandfathering rules being reevaluated
- Unconstitutionality of Insurance mandate

What is PPACA and other reforms having on premiums and plan designs?

- Small group 1-50 lives is getting hammered
- PPACA impact is approximately 1% to 5%, depending on the plan design that you had before reform took effect
- Trend is 11% to 14% for groups under 500 lives
- Businesses looking more and more at Consumer-Directed Health Plans, shifting financial responsibility to employees through increased premiums and higher deductibles, etc.
- HRAs and HSAs are being implemented in greater numbers
- Employees more engaged in costs of healthcare as well as alternatives.
- Wellness getting a closer look, but jury still out on the effect for small employers

The logo features a stylized mountain range with three peaks in shades of light blue and white, set against a dark blue background.

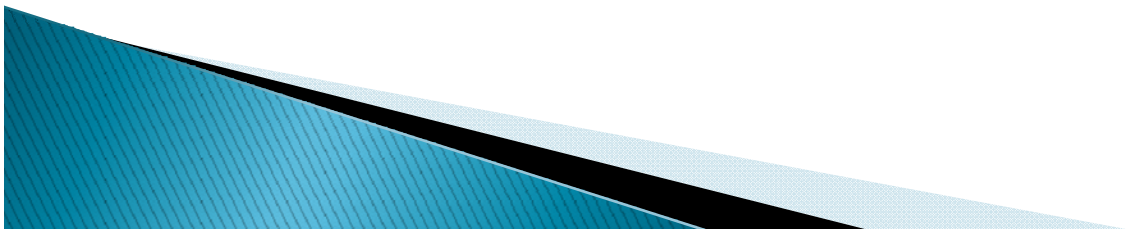
PEAK MEDICAL
MANAGEMENT LLC.

Revenue Cycle Management

Presented by Daniel Karpel, MBA, MHA

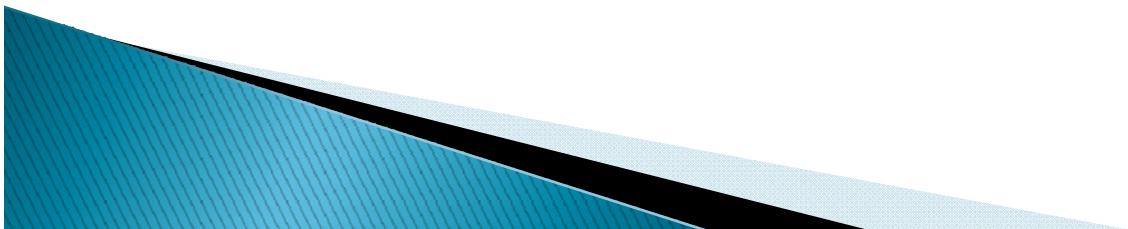
Introductions

- ▶ Daniel Karpel, MBA, MHA
 - Founder and CEO, Peak Medical Management, LLC
 - Chief Operating Officer (glorification of Practice Administrator), Radiology & Imaging Consultants, PC
 - Formerly compliance officer, managing underwriter, senior analyst, and other healthcare things and stuff for over 15 years.
- ▶ Let's meet the rest of us.

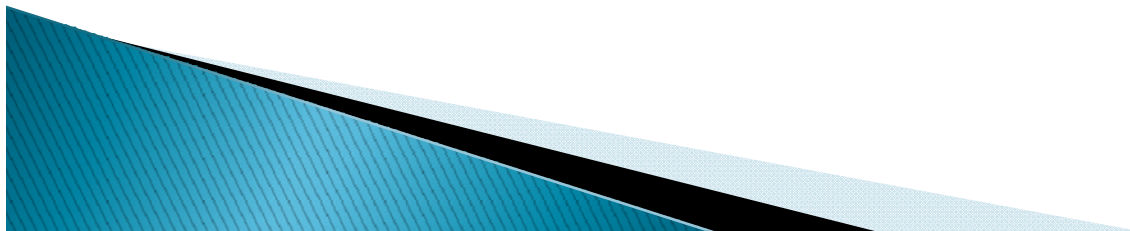
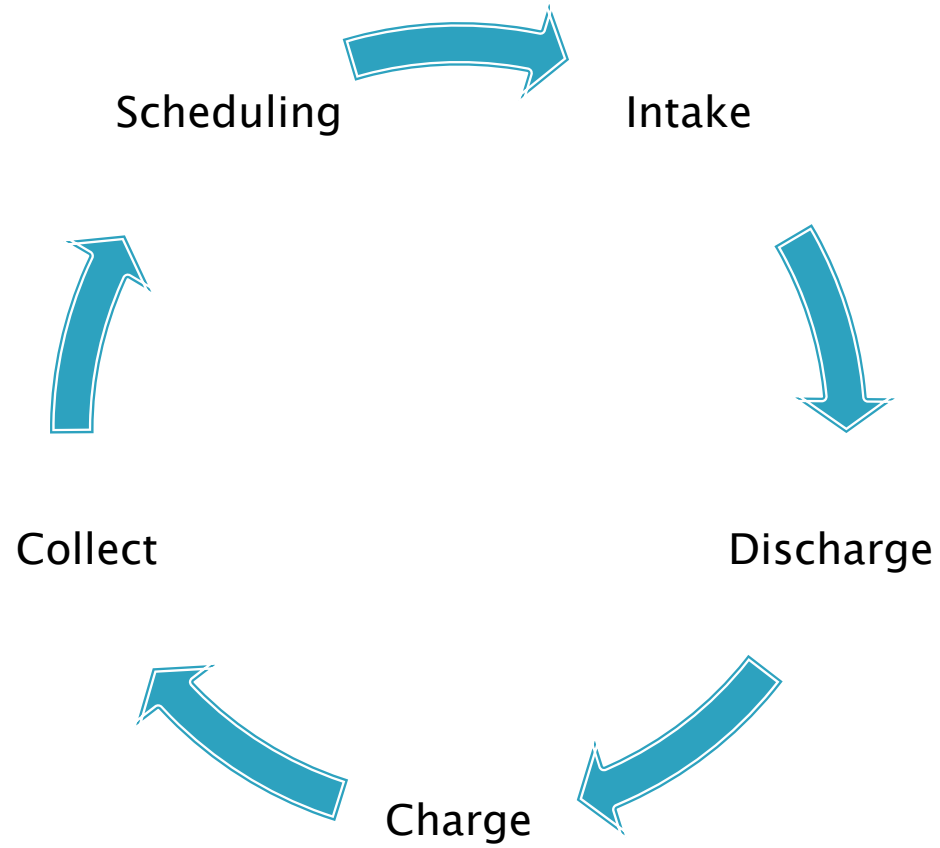


Revenue Cycle Management

1. What is this “Revenue Cycle”???
2. Management – are you managing or just reporting?
3. Revenue Analysis – Key Performance Indicators



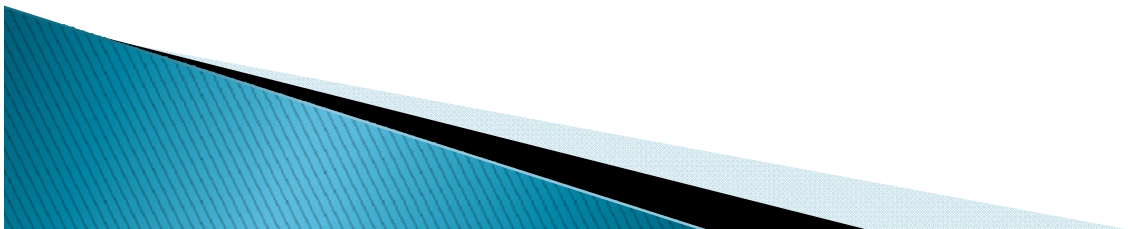
The Revenue Cycle



The Revenue Cycle

▶ Scheduling

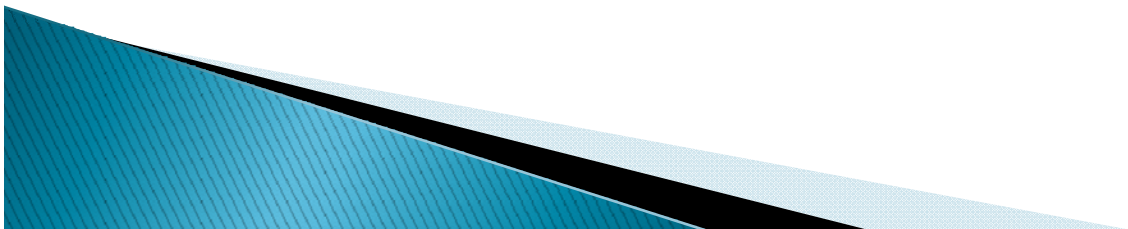
- The cycle begins when the phone rings.
 - **Did someone answer? Call back?**
- Book an appointment.
 - **Is there an outstanding balance?**
- Appointment Day...
 - Intake = Data Capture aka “facesheets” aka “intake forms” aka whatever-your-practice-calls the pieces of paper that impact your days in receivables.
 - **Verify against existing information?**
 - **Is the information legible?**
 - **Copy of Insurance Card?**
 - **Check the effective date on the card?**
 - **Take the required co-payment?**
 - **Collect any outstanding balance?**



The Revenue Cycle

▶ Discharge

- If ordering a procedure/surgery/diagnostic exam to be performed by your practice...
 - Does the procedure require preauthorization and if so, did you obtain pre-authorization and triple check the authorization number?
- If scheduling a follow-up appointment, will you require that all patient financial responsibility be paid in full?
 - (There is no right answer to that question.)



The Revenue Cycle

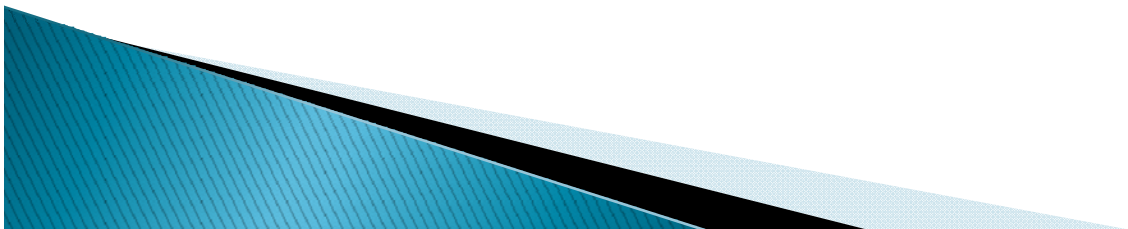
▶ Charging

◦ Coding

- Doctor coding?
- **Coders verifying doctor's CPT and ICD-9?** Software should be performing code edits, CCI edits and in some cases, local medical review policy (LMRP) and programmable edits (payor-specific).
- Coders certified?

▶ Charge Capture

- ▶ No reason it should not be 100% at all times.
 - ▶ **Reconciling daily ledger with coded charts and billing?**

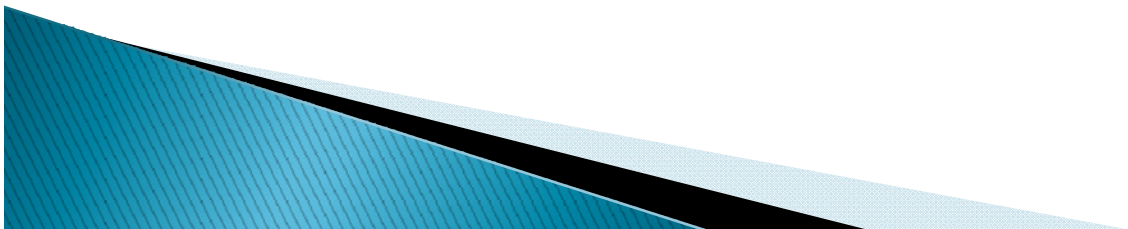


The Revenue Cycle

▶ Charging (Continued)

◦ Billing

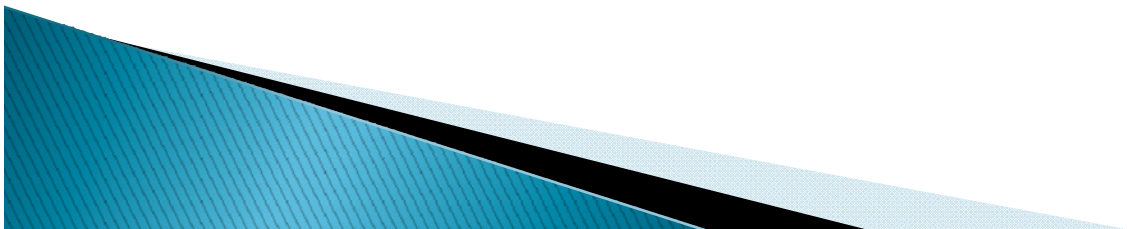
- You've reconciled your "superbills" aka "charge sheets" aka whatever-your-practice-calls-them to your ledger, you're ready to get bills out the door.
 - Reconciling clearinghouse report?
 - First level – i.e., clearinghouse issues?
 - Correcting and refileing rejections *daily*?
 - Second level – i.e., payor issues
 - Correcting and refileing rejections *daily*?
 - Great! You've captured 100% of your charges and 100% of them are in the hands of the payor. Now it's time to "Show me the money!!!"



The Revenue Cycle

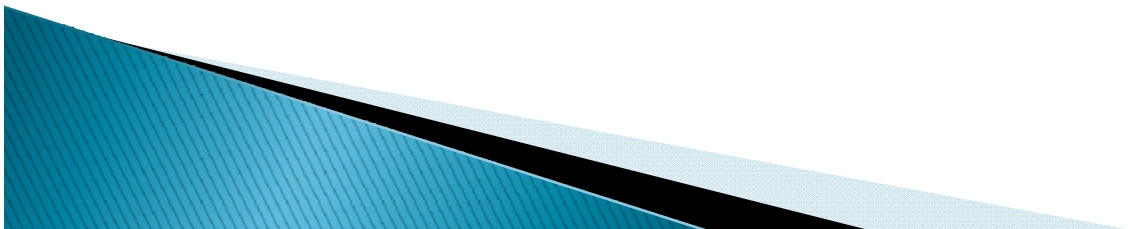
▶ Collections

- **Do you know what you *should* be collecting?**
 - Payor Matrix
 - You billed 100 charges today:
 - 20% Medicare (100% 2010 RBRVS)
 - 10% Medicaid (~88% 2010 RBRVS)
 - 10% Tricare (95% RBRVS)
 - 10% BCBS (CO Anthem) (115% RBRVS)
 - And so on...so you should know what you can expect in general, but are you
 - **Following up???**
 - **Denials management??**



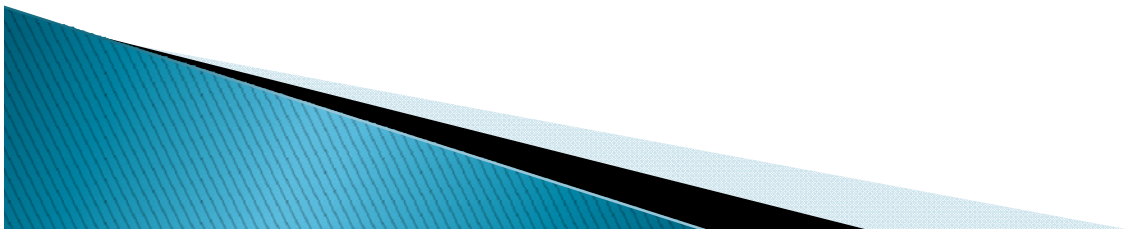
Management

- ▶ All is not lost however. Unless...
 - **Are you managing or just reporting?**
- ▶ Frequent, preferably continuous operational assessment management.
- ▶ Assess your practice with key performance indicators.



Key Performance Indicators

- ▶ Adjusted Collection Percentage
- ▶ Days Charges in Accounts Receivable
- ▶ Total Write-offs as a Percentage of Gross Charges
- ▶ Total Write-offs as a Percentage of Adjusted Charges
- ▶ Bad Debt Recovery as a Percentage of Collection Agency Write-offs
- ▶ Billing/Collection Expense Percentage
- ▶ Billing/Collection Cost per Procedure
- ▶ Accounts Receivable Aging Percentage Over 120 Days



Key Performance Indicators

Adjusted Collection Percentage

Formula: $(\text{Adjusted Collections} \div \text{Adjusted Charges}) \times 100$ or...

Definitions:

- ▶ Adjusted (Net) Collections: (Gross Collections – Collection Offsets)
- ▶ Adjusted Charges: (Gross Charges – Total Adjustments)
- ▶ Gross Collections: Revenue collected from Gross Charges
- ▶ Collection Offsets: Refunds of dollars collected in error + returned checks
- ▶ Gross Charges: Full dollar amount of all services rendered to patients
- ▶ Total Adjustments: Amounts which were never expected to be collected, by virtue of laws, regulations, contracts or internal policies applicable to the services provided by the entity

The adjusted collection percentage is a measure of the effectiveness of a business in collecting on accounts that are available for collection.

Key Performance Indicators

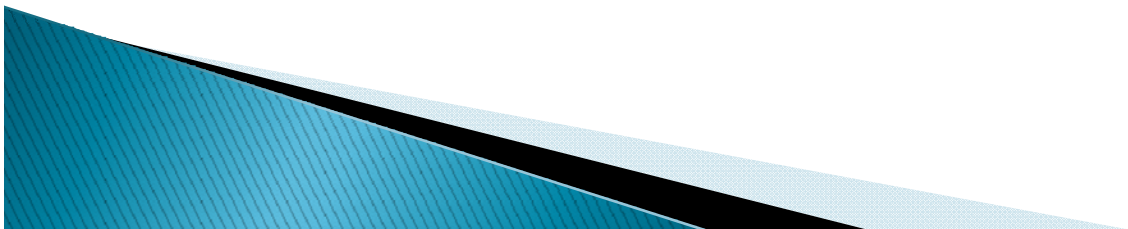
Days Charges in Accounts Receivable (DSO)

Formula: $(\text{Total A/R Balance} \div \text{Average Daily Gross Charges})$

Definitions:

- ▶ Average Daily Gross Charges: $(\text{Average Monthly Gross Charges} \div 30)$

The days charges in accounts receivable indicator provides a rough measure of the amounts that are outstanding in the accounts receivable. This measure provides a context for evaluating the total accounts receivable balance among practices whose operations are very different in size and scope. Recommend using a 6 to 12 month average.



Key Performance Indicators

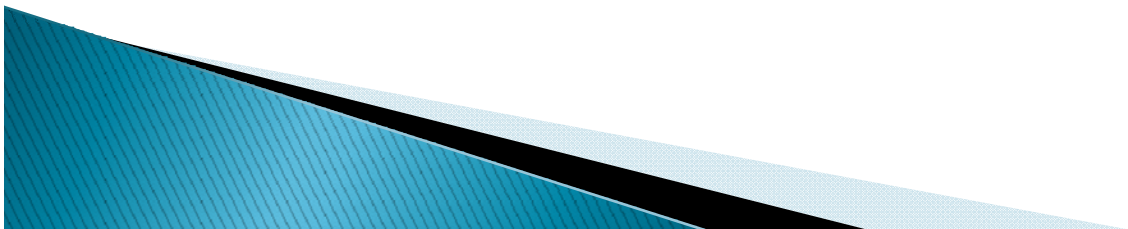
Total Write-offs as a Percentage of Gross Charges

Formula: $(\text{Total Write-offs} \div \text{Gross Charges}) \times 100$

Definitions:

- ▶ Total Write-offs: Amounts that were expected to be collected, but the organization was unsuccessful in collecting. Bad debt, bankruptcy, non-covered services, timely filing denials, small balance, return mail (unable to locate the responsible party), and patient deceased all are reasons money may not be collected as originally anticipated.
- ▶ Gross Charges: Full dollar amount of all services rendered to patients.

This key indicator represents the relationship between the total value of all services billed (gross charges) and the balances that are not collected and are removed from the A/R books as write-offs. The expectation at the time the services were billed was that they were available to the organization for collection.



Key Performance Indicators

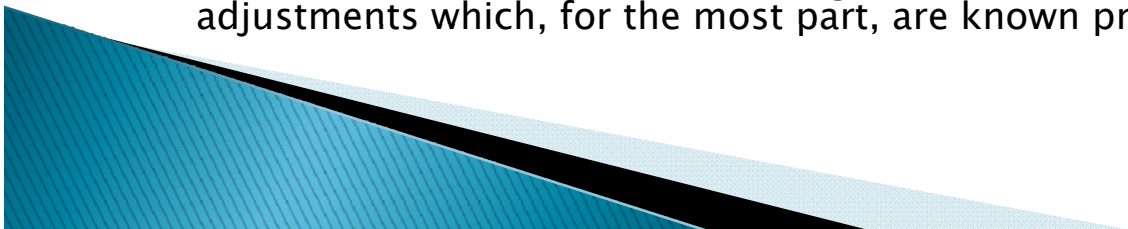
Total Write-offs as a Percentage of Adjusted Charges

Formula: $(\text{Total Write-offs} \div \text{Adjusted Charges}) \times 100$

Definitions:

- ▶ Total Write-offs: Amounts that were expected to be collected, but the organization was unsuccessful in collecting. Bad debt, bankruptcy, non-covered services, timely filing denials, small balance, return mail (unable to locate the responsible party), and patient deceased all are reasons money may not be collected as originally anticipated.
- ▶ Adjusted Charges: $(\text{Gross Charges} - \text{Total Adjustments})$
- ▶ Gross Charges: Full dollar amount of all services rendered to patients.
- ▶ Total Adjustments: Amounts which were never expected to be collected, by virtue of laws, regulations, contracts or internal policies applicable to the services provided by the entity.

Total write-offs as a percentage of adjusted **charges** is closely related to the previous key indicator, total write-offs as a percentage of gross charges. It adds another dimension to the overall analysis by calculating the statistic after removing from consideration the adjustments which, for the most part, are known prospectively.



Key Performance Indicators

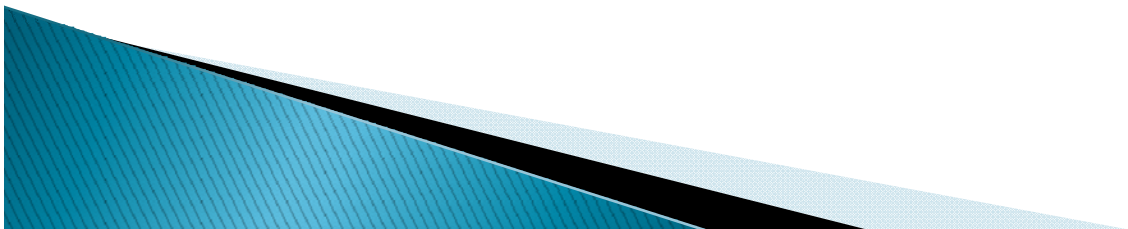
Bad Debt Recovery as a Percentage of Collection Agency Write-offs

Formula: $(\text{Amount Recovered by External Collection Agency} \div \text{Collection Agency Write-offs}) \times 100$

Definitions:

- ▶ Collection Agency Write-offs: Amounts that, in an ideal world, the practice would have collected from patients, but which the patients failed to pay and were sent to an outside collection agency for additional pursuit; e.g., bad debt write-offs.

What constitutes a good value for this statistic is problematic because of the hidden interaction between the effectiveness of internal collection processes and the performance of the collection agency. Although this indicator focuses on collection agency performance, it can be largely affected by efforts to collect more efficiently internally.



Key Performance Indicators

Billing/Collection Expense Percentage

Formula: $(\text{Billing/Collection Expense} \div \text{Adjusted Collections}) \times 100$

Definitions:

- ▶ Billing/Collection Expense: All costs identified as incurred in the process of collecting, recording and transmitting charge information, plus the costs of collecting, posting and depositing payments for these services. Fees paid to mailing services and to collection agencies are included here.
- ▶ Adjusted Collections: (Gross Collections – Collection Offsets)
- ▶ Gross Collections: Revenue collected from Gross Charges.
- ▶ Collection Offsets: Refunds of dollars collected in error + returned checks.

The primary reason for analyzing the relationship between the expenses that are incurred for billing/collection purposes and the adjusted collections is to evaluate the efficiency of the billing/collection process.

- Can analyze by CPT, patient visits, etc.

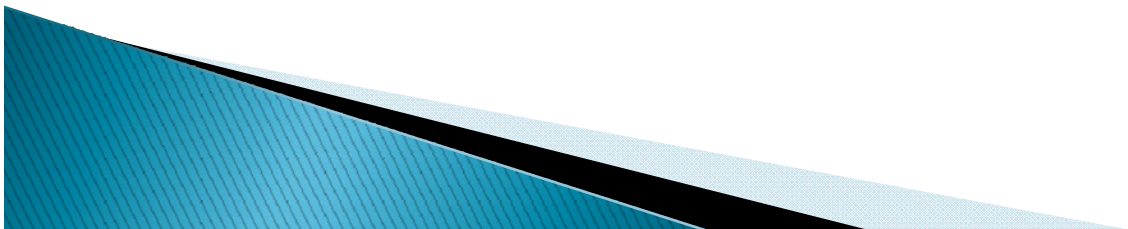


Key Performance Indicators

Accounts Receivable Aging Percentage Over 120 Days

Formula: $(\text{Dollars Aged Over 120 Days} \div \text{Total A/R Balance}) \times 100$

- ▶ Recommend calculating A/R aging from billing date rather than from date of service. **By the way, how long is it taking you to go from discharge to billing...?**
- ▶ When managing outstanding accounts receivable, prevailing wisdom is that the older the account, the more difficult it becomes to collect.
- ▶ It is important to analyze this key indicator by responsible payor, if possible, to facilitate the identification of specific payor problems within the aging category.



Other Performance Indicators

- ▶ Gross Collection Percentage
- ▶ Total Adjustments as a Percentage of Gross Charges
- ▶ Collection Agency Write-offs as a Percentage of Gross Charges
- ▶ Collection Agency Write-offs as a Percentage of Adjusted Charges
- ▶ Collection Offsets (Refunds and Returned Checks) as a Percentage of Gross Charges

