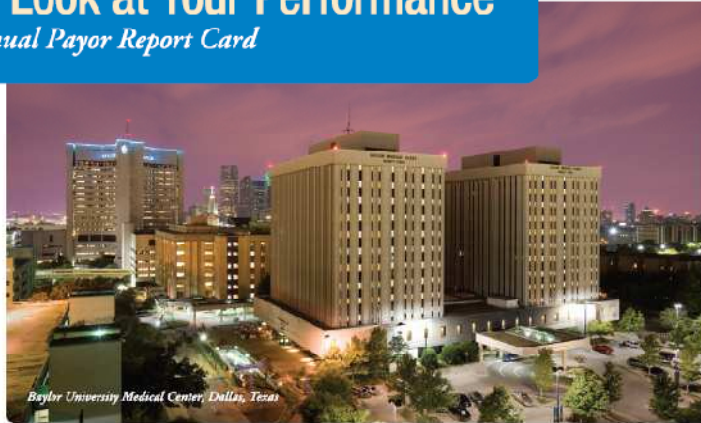


A Close Look at Your Performance

Seventh Annual Payor Report Card

FALL 2010



Baylor University Medical Center, Dallas, Texas

HFMA Lone Star Chapter - May 19, 2011
James Foster
Julie Tipps



Baylor Health Care System



Financial

- \$3.9 billion in total assets
- \$3.4 billion total operating revenue
- \$452 million in community benefits

Facilities and People

- 1.4 million patient served annually
- 25 owned, joint-ventured or affiliated hospitals
- 3,532 licensed beds
- 20,000 employees
- 4,535 physicians on active staff
- 450 physicians in HealthTexas Provider Network (largest group of employed physicians in Texas)
- 21 ambulatory surgical/endoscopy centers
- 31 satellite outpatient facilities



FY09 Statistics

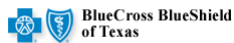
2

Hospital Ratings Around

U.S. Dept of Health and Human Services
Hospital Compare



THE LEAPFROG GROUP
Informing Choices. Rewarding Excellence.
Getting Health Care Right.

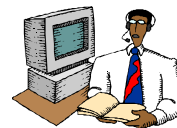


3

What is Baylor's Payor Report Card?

1. Qualitative – *satisfaction survey*

600+ Baylor employees who interact with managed care payors as part of job



2. Quantitative – *financial reports*

- ❖ Late payments
- ❖ Underpayments
- ❖ Registration Cost Per Claim
- ❖ Collection Cost Per Claim
- ❖ Denials



4

Purpose for Report Card

1. Payor accountability for obligations in contract

- Identify patients and products correctly
- Accurate eligibility and/or benefit information
- Timely responses to requests (e.g., precerts)
- Appropriate communication as defined by language
- Pay timely and accurately

2. Overall satisfaction comparison to peers

3. Provide focus for improvement

4. Use in negotiations

5

Development of the Payor Report Card

1. Staff from Operational Areas Developed Questions
(Managed Care, Billing, Collections, Access and Care Coordination)
2. Managed Care Dept Reviewed/Validated Contract Requirements
3. Marketing Research Advised on Number of Questions and Developed User-Friendly Wording to Achieve Most Valid Data
4. Questions and Metrics Reviewed Every Year



6

Top 10 Payors Surveyed

General Services Contracts

- Aetna
- Amerigroup
- Blue Cross Blue Shield
- Cigna/Great West
- Coventry/FirstHealth
- HealthSmart
- Humana
- MultiPlan/PHCS
- Parkland Health Plan
- Texas True Choice
- UnitedHealthcare

Transplant Contracts

- Aetna
- Blue Cross Blue Shield
- Cigna
- Coventry/First Health
- Humana
- Interlink
- LifeTrac
- Optum Health
- Texas True Choice

7



Qualitative Measurement Satisfaction Survey



Who Participated In the Survey?



- 600+ BHCS employees who interact with managed care payors
 - ✓ Registration Staff
 - ✓ Insurance Verification Staff
 - ✓ Care Coordinators/Social Workers
 - ✓ Billing Staff
 - ✓ Collections Staff
 - ✓ HealthTexas physician practice staff



91% response rate

9

Surveys Divided By Work Area



50 Total Questions into Five Sections

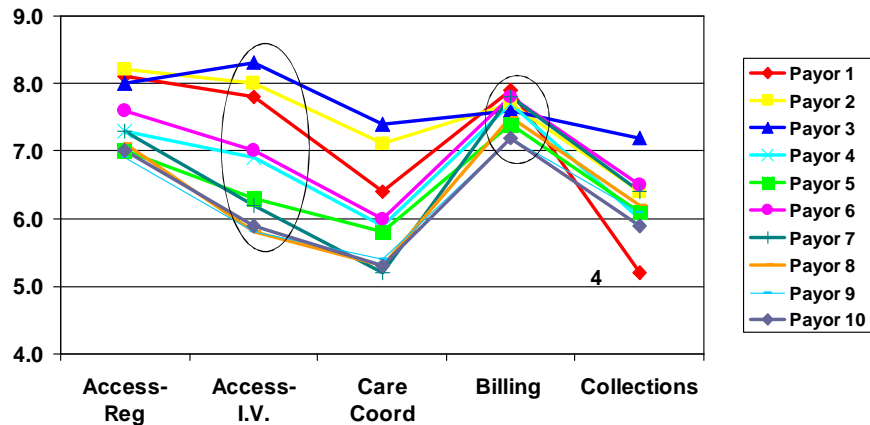
1. Access Services Registration - ID card info
2. Access Services Ins Verification – eligibility, precerts, benefits
3. Care Coordination – recerts, D/C planning
4. Billing – payor edits, billing reports
5. Collections – online claim system, customer service, payor requests for additional info

Transplant Payors (same categories as above) but some questions unique to transplant contracting



10

Average Score by Department – FY10



Qualitative Metric Surveys Emailed to Staff

BHCS Managed Care Payor Survey - Message

Dear Julie,

Baylor's Office of Managed Care is conducting the 5th Annual Managed Care Payor Report Card Survey and we need your help. You have been selected because your job involves working with managed care companies, and we are asking for your honest feedback on these companies.

This is our opportunity to rate how well insurance companies perform their duties. As a result of this survey, we have been able to influence positive changes with payors.

This report card is shared with BHCS senior leadership, local health organizations and most importantly in our meetings with each payor. It is a highly valuable tool for Baylor, and would not be possible without your participation. So, thank you very much for your help.

Please allow about 20 minutes to complete, and the deadline to complete the survey is June 30. To complete the survey, please click on the following link: http://www.surveymonkey.com/s.aspx?sm=NTrHkww_2fwja6ulw_2f_2fjit7g_3d_3d

If you have any questions, please call the Office of Managed Care at 214-820-7808.

Dianne Grussendorff
Vice President, BHCS Office of Managed Care

Sample of Online Survey



File Edit View Favorites Tools Help

BAYLOR Health Care System

2008 Managed Care Payor Survey (Access-Registration)

3 / 4

Q3. The ID cards provided by the payor have the product type listed (e.g., HMO, PPO, POS).

	Always	Usually	Sometimes	Never	N/A
United	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aetna	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cigna	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Humana	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HealthSmart	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BCBS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unicare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Texas True Choice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PHCS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
First Health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<< Prev Next >>

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Survey Question Results



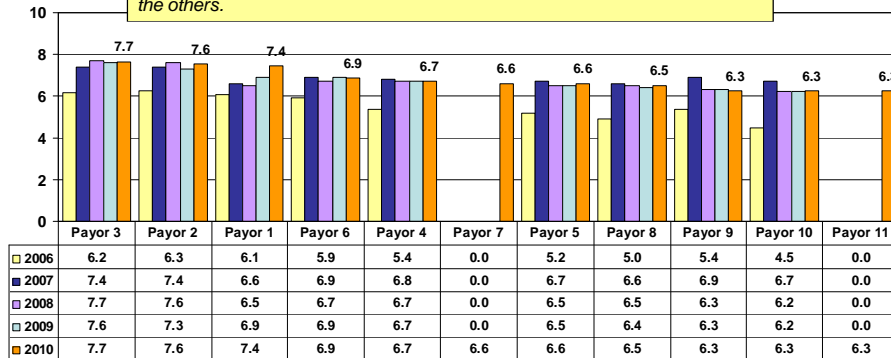
2. I receive adequate discharge planning assistance from the insurance case manager.

Payor	Always	Usually	Sometimes	Never	N/A	Response Count
Payor 1	30	26	14	4	12	86
Payor 2	23	35	13	2	13	86
Payor 3	22	33	14	3	14	86
Payor 4	4	25	22	7	28	86
Payor 5	4	16	23	10	33	86
Payor 6	16	30	22	6	12	86
Payor 7	0	15	13	17	41	86
Payor 8	4	18	25	10	29	86
Payor 9	3	16	22	12	33	86
Payor 10	3	14	21	12	36	86
Payor 11	4	18	12	15	37	86

Overall Satisfaction Average Score Composite Score - All Areas*



All payors' scores improved somewhat over last year. **Payor 3** ranked highest for fourth consecutive year. **Payor 1's** score improved more than the others.



Rating is based on a 10 point scale where 10 = Completely Satisfied and 0 = Completely Dissatisfied.

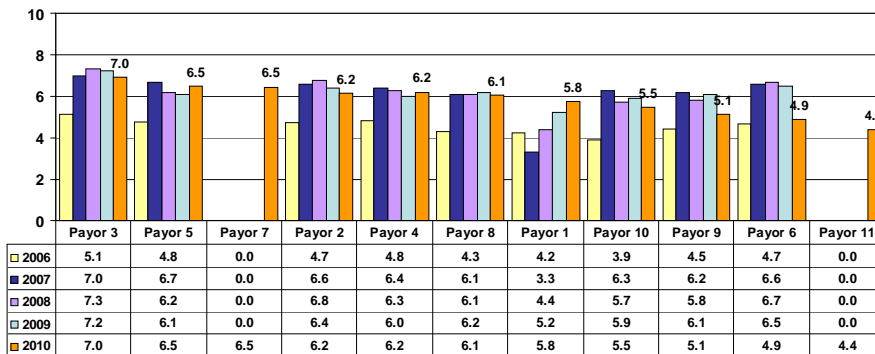
*2010 Composite Score created using an equally-weighted average for overall satisfaction for each section: Access Services, Care Coordination, Billing and Collections.
0.0 = payor not measured that year

15

Overall Satisfaction Average Score Collections



More payors' scores worsened rather than improved over last year. **Payor 1's** scores have consistently improved. **Payor 6's** score dropped 1.6 points, more than all other payors.



Rating is based on a 10 point scale where 10 = Completely Satisfied and 0 = Completely Dissatisfied.

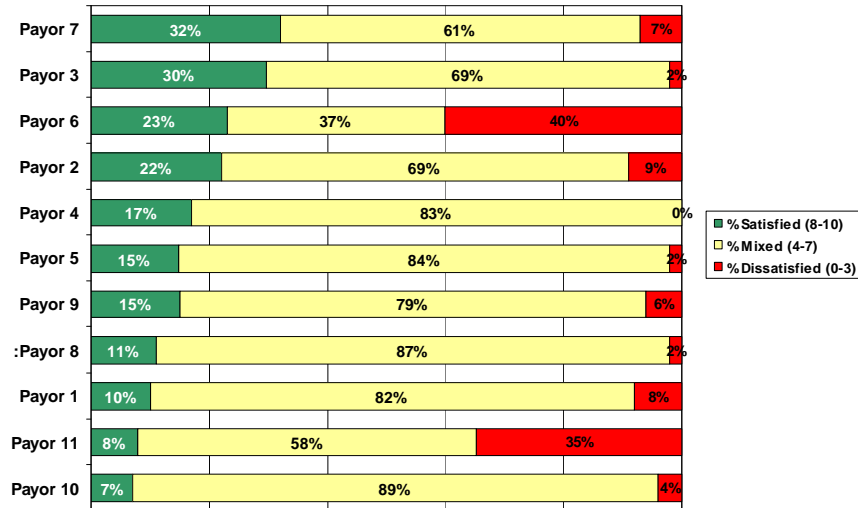
0.0 = payor not measured that year

16

Overall Satisfaction Dashboard Collections



On a scale from 0-10, with 0 being "Completely Dissatisfied" and 10 being "Completely Satisfied," – rate your overall satisfaction with each payor's collection services

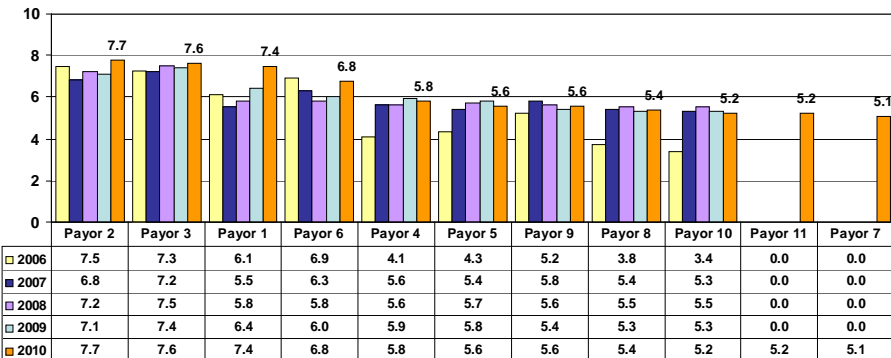


17

Overall Satisfaction Average Score Care Coordination



Payor 2 ranked highest this year, taking lead back from **Payor 3**. While most payors' scores have no notable trend, **Payor 1** has consistently improved over last few years.



Rating is based on a 10 point scale where 10 = Completely Satisfied and 0 = Completely Dissatisfied.

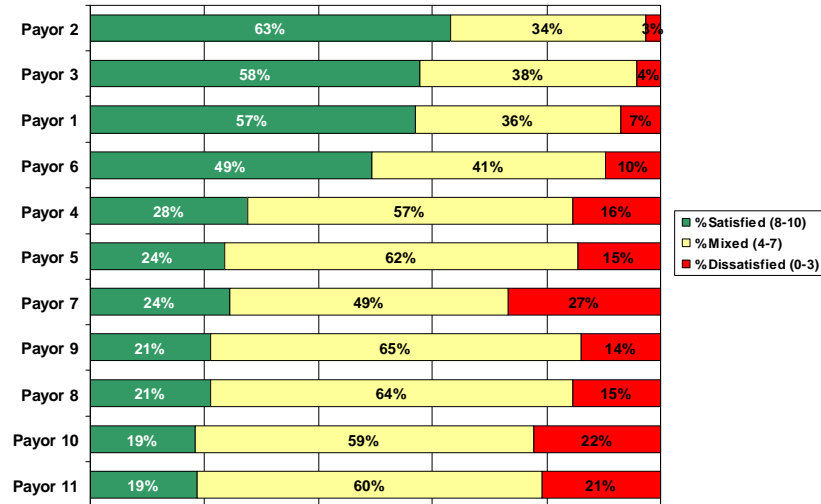
0.0 = payor not measured that year

18

Overall Satisfaction Dashboard Care Coordination



On a scale from 0-10, with 0 being "Completely Dissatisfied" and 10 being "Completely Satisfied," – rate your overall satisfaction with each payor's care coordination services



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Employee Comments



Q: Are there any other comments you'd like to make regarding the service of any of the payors you deal with? (Please specify any payors by name.)

- Good response – over 100 individual comments
- Payors very interested
- Some issues only raised in comments
 - problem clients
 - language barriers
 - unusual issues not captured in questions



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Employee Comments



Registration

“**Payor 4, Payor 9**, have multiple carriers on them [ID cards]; it is hard to tell which one is the primary carrier. It is hard to tell which insurance to use”

Insurance Verification

“**Payor 2** fails to give information on preventive care via website. **Payor 3's** website also does not offer info about preventive care. **Payor 1** website does not give information about whether or not notification is required for out-patient services. **Payor 6** does not reveal how much is met from a patient's deductible or OOP through the automated line.”

“**Payor 1** customer reps are the most difficult ones. It seems the offices in India, Jamaica are the difficult ones to get cooperation from. It would be nice if our rep w/**Payor 1** can help assist us in this matter.”

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Employee Comments



Care Coordination

“It has been very difficult with finding Home care agencies for **Payor 1, Payor 2** and **Payor 6**. This has increased time for the hospital discharging patients. There does not seem to be an urgency on the payor's part to move the patients out of the hospital.”

“**Payor 3** has two to four people calling me on the same patient wanting clinical or stating a complaint. One is the person requesting the clinical, one is the case manager, and one may be the catastrophic case manager, etc. – all with different fax numbers and phone numbers – they should have one person on their end getting the clinical and filtering out to all their other people.”

22

Employee Comments



Collections

“**Payor 1** would rather deny a claim 6 times than pay it. **Payor 2 & Payor 6** are the best payers to correct an issue once an error is pointed out.”

“**Payor 7** requests more medical records than any other carrier. They will ask for records on a patient every time we submit a claim even if other claims have had records sent. This is very costly and time consuming, not to mention delay of payment.”

“**Payor 2:** Splits the claims into too many small pieces often missing charges.

“**Payor 10:** Continues to deny our claims as OON. Greatly delays our A/R resolution and causes additional time and manpower to get claim reprocessed.”

23



Quantitative Measurement Financial Reports



Financial Reports Included

- Administrative Cost to Register
- Administrative Cost of Billing & Collecting Per Claim
- Dollars Tied up in Clinical Denials
- Denials as a Percentage of Cases
- Late Payment Dollars as a Percentage of Cases
- Late Payment Dollars as a Percentage of Net Revenue
- Underpayment Dollars as a Percentage of Cases
- Underpayment Dollars as a Percentage of Net Revenue



25

Cost of Doing Business

- Developed process to quantify administrative cost of billing/collections
- Used “TRAC” system, assigning values to tasks according to labor time
 - Claims rework
 - Claims denials
 - Clinical reviews
 - Medical records

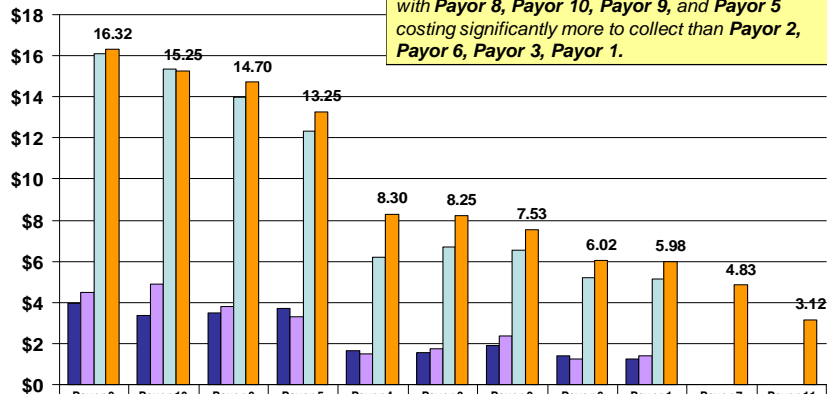


26

Labor Cost to Collect Per Claim*



The relative position of payors from highest to lowest cost to collect has been consistent year over year, with **Payor 8, Payor 10, Payor 9, and Payor 5** costing significantly more to collect than **Payor 2, Payor 6, Payor 3, Payor 1.**



	Payor 8	Payor 10	Payor 9	Payor 5	Payor 4	Payor 3	Payor 2	Payor 6	Payor 1	Payor 7	Payor 11
Cost/Claim 07	3.95	3.36	3.5	3.67	1.63	1.54	1.91	1.38	1.27	0	0
Cost/Claim 08	4.51	4.91	3.80	3.30	1.50	1.74	2.33	1.26	1.41	0	0
Cost/Claim 09**	16.10	15.37	13.97	12.33	6.16	6.70	6.51	5.20	5.15	0	0
Cost/Claim 10	16.32	15.25	14.70	13.25	8.30	8.25	7.53	6.02	5.98	4.83	3.12

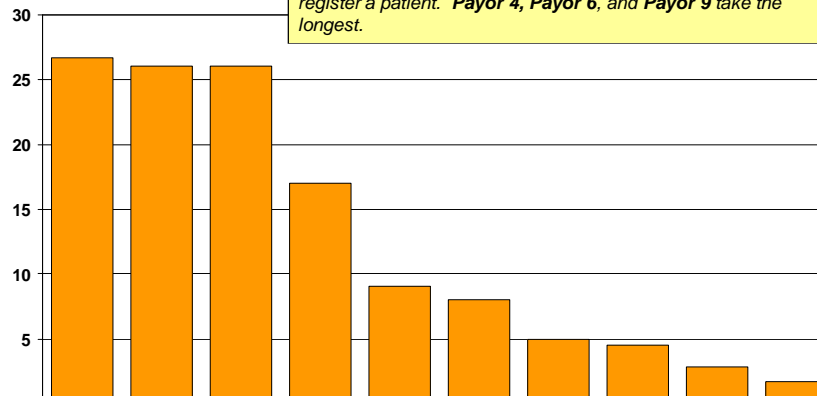
*Labor Cost to Collect Methodology: Each activity required by collectors to get a payor's claim paid is tracked electronically, assigned a time value, and average labor cost to determine the administrative cost to collect per payor per claim.
 **FY09 increase due to improvements in data collection process; reflects collection costs more accurately than previous years.

27

Average Time To Register By Payor (in minutes)



There is a big difference among payors in the time it takes to register a patient. **Payor 4, Payor 6, and Payor 9** take the longest.



	Payor 4	Payor 6	Payor 9	Payor 3	Payor 10	Payor 2	Payor 1	Payor 5	Payor 11	Payor 7
Time To Register	27	26	26	17	9	8	5	5	3	1.7

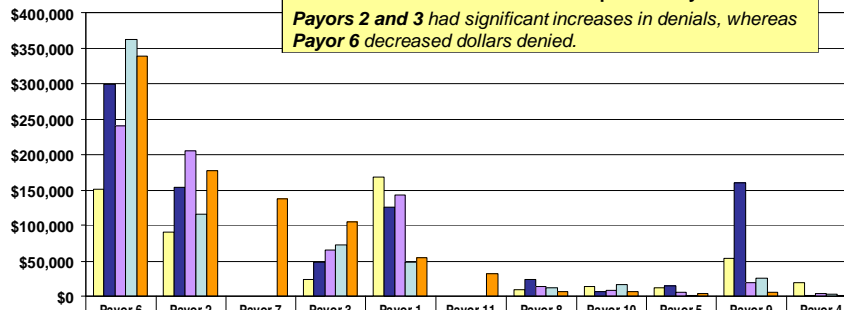
Source: BHCS Management Engineering Time Studies

28

Dollars in Denial Per Month Inpatient Accounts – FY10



FY10 Inpatient Denials = \$10.4 million
71% was overturned and paid to Baylor
Payors 2 and 3 had significant increases in denials, whereas Payor 6 decreased dollars denied.



	Payor 6	Payor 2	Payor 7	Payor 3	Payor 1	Payor 11	Payor 8	Payor 10	Payor 5	Payor 9	Payor 4
Denials/Mo FY06	150,676	90,650	0	23,771	168,100	0	9,085	13,585	11,504	52,838	18,166
Denials/Mo FY07	298,470	153,017	0	48,577	125,568	0	24,623	7,298	14,973	160,010	1,824
Denials/Mo FY08	240,428	205,939	0	64,761	142,145	0	13,041	8,655	4,728	18,461	3,887
Denials/Mo FY09	362,903	116,353	0	72,272	47,431	0	11,474	15,573	1,330	25,049	2,216
Denials/Mo FY10	339,053	176,817	137,302	105,233	54,992	31,926	6,559	6,555	3,856	5,328	1,190

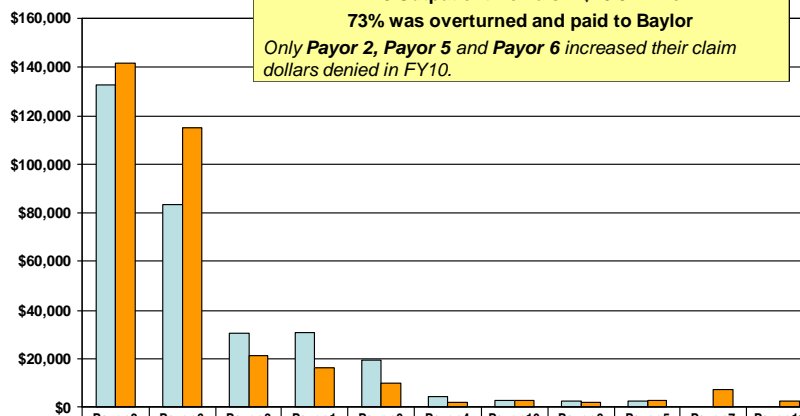
Source: FY10 DRC Report
 0 = payor not measured that year

29

Dollars in Denial Per Month Outpatient Accounts



FY10 Outpatient Denials = \$ 3.9 million
73% was overturned and paid to Baylor
Only Payor 2, Payor 5 and Payor 6 increased their claim dollars denied in FY10.



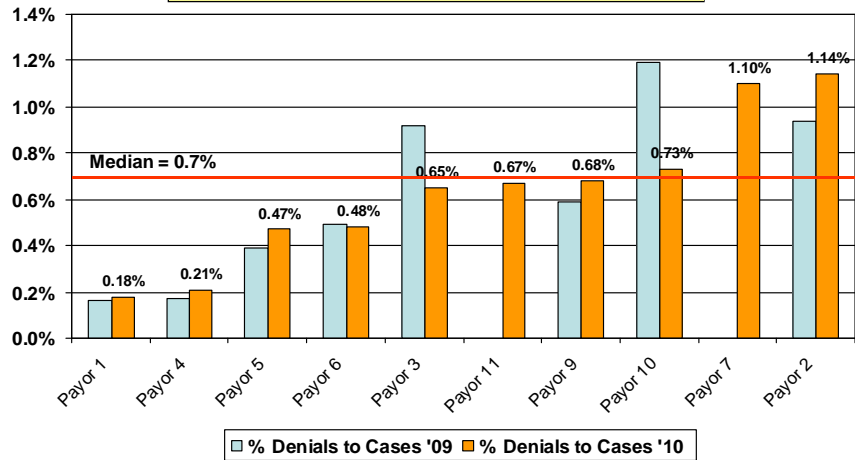
	Payor 2	Payor 6	Payor 3	Payor 1	Payor 9	Payor 4	Payor 10	Payor 8	Payor 5	Payor 7	Payor 11
Denials/Mo FY09	132,578	83,392	30,405	30,928	19,251	4,344	2,796	2,403	2,136	N/A	N/A
Denials/Mo FY10	141,321	115,266	21,475	16,247	10,147	2,080	2,757	1,845	2,821	7,325	2,134

N/A = payor not included in survey that year

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Denials as a % of Total Cases

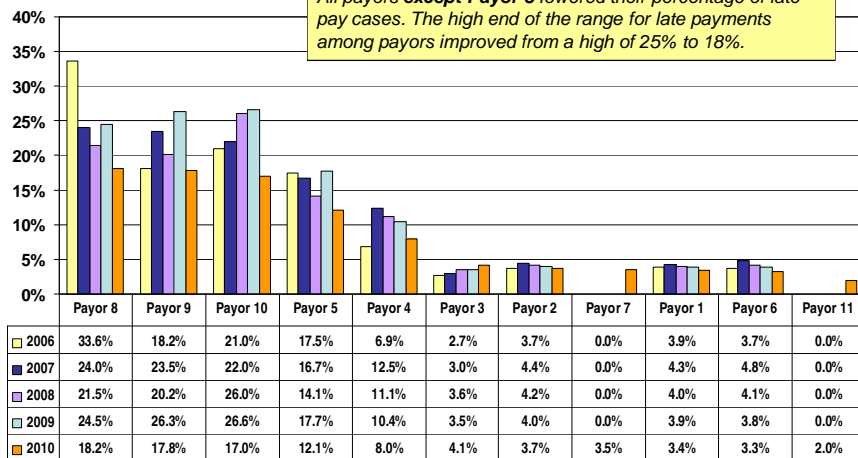
Data shows **Payor 2** and **Payor 7** with a higher percentage of denials than others, and **Payor 1** and **Payor 4** with the lowest.



31

Late Payments as a Percentage of Cases

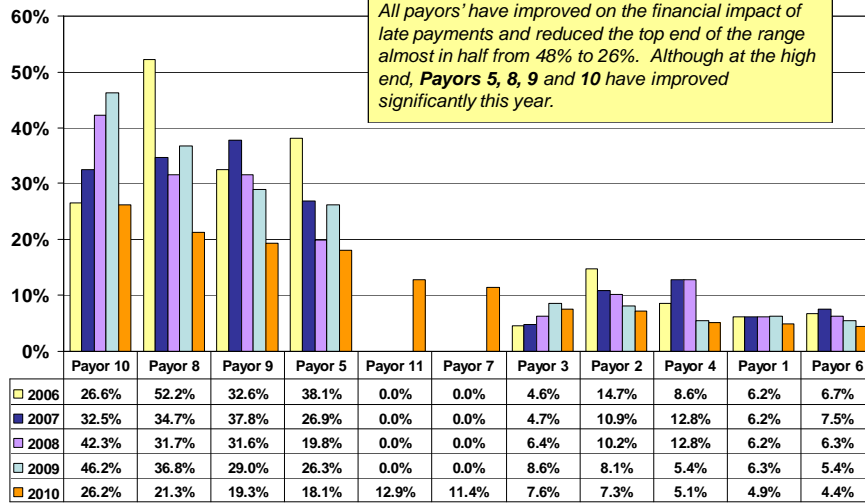
All payors **except Payor 3** lowered their percentage of late pay cases. The high end of the range for late payments among payors improved from a high of 25% to 18%.



0.0 = payor not measured that year

32

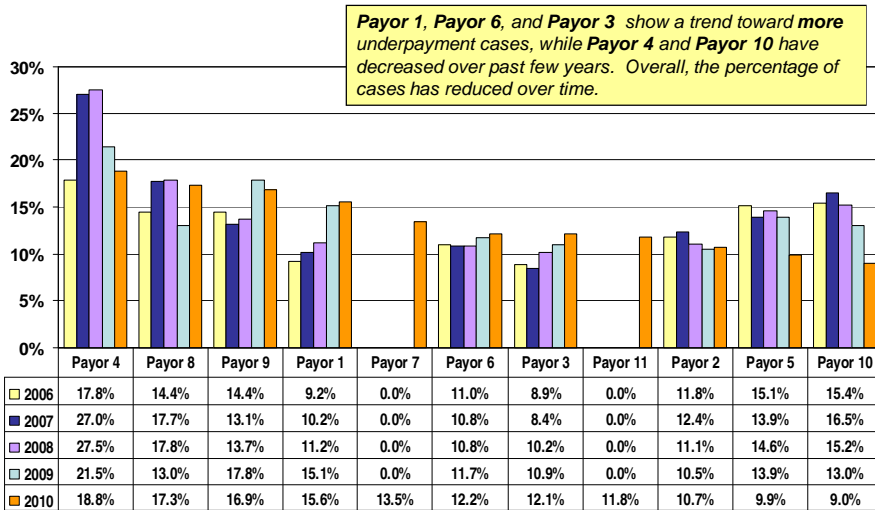
Late Payments as a Percentage of Net Revenue



0.0 = payor not measured that year

33

Underpayments as a Percentage of Cases



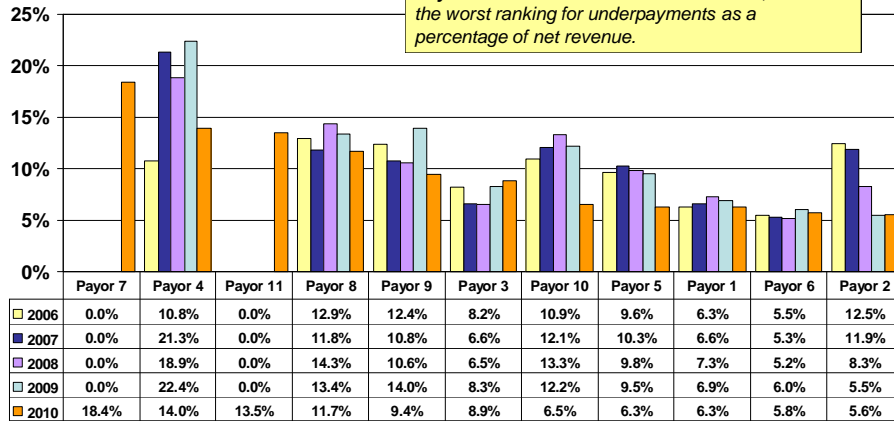
0.0 = payor not measured that year

34

Underpayments as a Percentage of Net Revenue



All payors **except Payor 3** improved over last year. **Payor 7** was included for first time in 2010, and had the worst ranking for underpayments as a percentage of net revenue.



0.0 = payor not measured that year

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Effectiveness of Report Card



Who Gets the Report? What is the Value?



Our purpose in sending the report is to:

- 1) Show our commitment to work collaboratively with our payors,
- 2) Bring more transparency in payor performance, and
- 3) Help educate the healthcare community on the complex transactional processes that impact overall health care costs.

- Payors (mailed and discussed in operational meetings)
- Top 25 Employers – sent to CEO and HR executive
- Presented to BHCS Hospital Board
- Presented to Voluntary Hospital Assn.
- Presented at Various National Conferences (Chicago, Atlanta, Baltimore, Kansas City, New Orleans, etc)
- DFW Hospital Council
- Dallas/Ft.Worth Business Group on Health
- DFW Health Industry Council
- Texas Medical Association
- Dallas County Medical Society
- Texas Department of Insurance
- Texas Hospital Association
- Texas Health and Human Services Commission
- Dallas County Commissioner, Health Initiatives

Value to Employers



“From an employer’s perspective, I was interested to see **how our particular health plan ranked among the others**. Choosing a plan that offers the best value to our employees is paramount, and Baylor’s report card highlights a payor’s performance in areas that can impact that value. It is a helpful tool in evaluating a health plan’s performance.”

Executive Compensation & Benefits Consultant
Energy Future Holdings Corporation (TXU)



Value to Other Providers



"Baylor's payer scorecard has been a game-changer in the North Texas healthcare market by leveling the playing field in terms of transparency in payer performance. We at Cleveland Clinic are modeling our payer report card initiative on **Baylor's industry best practice**. It is our hope that we can achieve a similar level of market interest and performance improvement from health plans here in Northeast Ohio."

**Michael McMillan, Executive Director
Managed Care, Cleveland Clinic**

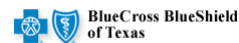
39

Payor Responses – Process Improvements



"The report card allows us to get a **look at our performance relative to our peers** from the perspective of a leading provider. In the areas where we may not score as well, we know to target those areas for additional training and coaching of our staff. In areas where we exceed our peers, we are able to give positive feedback to our staff for a job well done. I have found the Executive Summary section of the report to be an excellent snapshot of year over year performance and extremely helpful for measuring the impact of process improvements we have implemented. Additionally, the **Comments section of the Report Card is useful** for gaining specific feedback in areas where we **need to focus our energy**."

**J. Darren Rodgers, President
Blue Cross and Blue Shield of Texas**



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Payor Responses – Process Improvements



“Humana has taken a very pro-active position relative to monitoring our overall service performance through the eyes of our hospital partners, physicians and consumers. Baylor’s Payor Report Card is among the **most comprehensive external measurement tools available to DFW payors**. It has proven to be a very reliable data source for gauging our on-going transactional and service effectiveness.”

Ken Malcolmson, President
Humana



Baylor’s Payor Report Card provides insight on our performance from the viewpoint of those providing the health care services, so we can continue to strengthen relationships with the professionals at Baylor. The survey results from a nationally recognized organization like Baylor are great validation that **CIGNA’s** efforts toward collaboration are working, and **we will use the Report Card to further enhance our processes.**”

David Toomey, President
CIGNA HealthCare of Texas

Payor Responses – Process Improvements



- Management Summary
- Home Health Agency Process



Payor Responses – Process Improvements

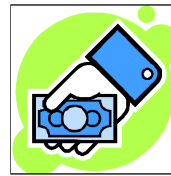


"At 90% employee response rate, Baylor's Third Annual Report Card sets an industry benchmark and provides thoughtful feedback about the status of health care delivery issues across the DFW marketplace. The charts, organized around five dimensions, are well designed and quickly summarize the successful interactions between our organizations. This publication is truly a valuable tool as we strive to build on our strengths and improve on our communication, operations and processes between Baylor Health Care System and Aetna."

Carl King, Regional President
Aetna



Call Center Improvement



Disputed Claim Process

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Lessons Learned



- Compare cost/benefit of outsourcing employee survey versus handling in-house
- Even if outsourcing, provide in-house contact person for employee questions.
- Require each person to complete survey – even if "N/A" or "Don't Know"
- Year over year trends important
- Comparison to peers important
- Very useful for addressing in ongoing operational meetings with payors as well as in negotiations



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Lessons Learned

- Most time-consuming part is developing questions and building online survey tool
- Make sure questions are clear to respondents
- Compile accurate and complete employee list for best response rate and meaningful results
- Determine how to motivate (incentives, competition, mandatory)
- Give regular updates during survey time to managers re: staff response rates



45

Future Plans

- Patient portion as % of Net Revenue
- Percentage of “limited benefit” accounts
- Percentage of high-deductible plans
- Possibly un-blind names?

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Return on Investment



Fee for web-based Survey Tool - \$200
Preparing/Overseeing the Survey – 60 hours
Printing of 150 Report Card Books - \$2,000

**Using data in payor negotiations and for process
improvements**

PRICELESS



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Thank you!
Questions?

JamesF@BaylorHealth.edu
Juliet@BaylorHealth.edu

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Survey Questions

Access Services - Registration

1. The ID card provided by the payor clearly identifies the information I need to accurately register the patient (e.g. phone #s for pre-cert, care coordination, and address for claims).
2. The ID cards provided by the payor have the product type listed (e.g. HMO, PPO, POS)
3. The ID cards provided by the payor have co-pays and deductibles clearly listed.

Access Services – Insurance Verification

1. The telephonic eligibility and benefits system provides complete information
2. The telephonic eligibility and benefits system provides accurate information
3. The automated telephonic pre-cert/authorization information is available.
4. The automated telephonic pre-cert/authorization system gives me all the information I need.
5. The online eligibility and benefits system provides complete information
6. The online eligibility and benefits system provides accurate information
7. The payor has an online pre-certification system
8. The payor's online pre-cert system includes a list of CPT-codes.
9. The online pre-cert/authorization information is complete
10. The online pre-cert/authorization information is accurate
11. The online benefits system clearly identifies exclusions or exceptions to standard process (e.g., notification for admission).

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Survey Questions

Care Coordination

1. The payor responds to re-certification requests within 24 hours
2. I receive adequate discharge planning assistance from the insurance case manager
3. Discharge planning resources provided by the payor are easy for me to access (e.g., home health agencies, nursing homes, DME, etc)
4. Clinical denials are accurate/appropriate
5. Payor provides accurate fax numbers for sending clinical reviews.
6. I receive timely communication from case management when a patient transitions from acute care to large case management

Billing

1. A transmission report can be used as proof of filing
2. Payor edits are easily understood
3. Payor's reason for the rejection of the bill is easy to understand.

Collections

1. When I call for status and speak to customer service, the claim is in the payor's system
2. Hold times are reasonable when I call a customer service rep
3. The payor has an online claims status system
4. The online claims status system is easy to use
5. The online claims status information is complete and accurate (i.e., I get all of the information I need)

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Survey Questions

Collections (cont'd)

6. The payor has a telephonic claims status system
7. The telephonic claims status system is easy to use
8. The telephonic claims status information is complete and accurate ((i.e., I get all of the information I need)
9. The pre-cert information is in the payor's claims adjudication system
10. It is easy to access customer service representatives who are knowledgeable about our contract
11. The payor requests additional information in order to pay the claim
12. When using the online tool or telephonic system regarding a claim pended for additional information, I am able to find out what is needed to get claim paid.
13. When talking to an insurance representative regarding a claim pended for additional information, I am able to find out what is needed to get claim paid.
14. During a status or follow-up call, payor acknowledges receipt of information needed to get claim paid.
15. The claim is processed within 30 days after additional information requested is forwarded to the payor
16. Reprocessing of the claim is handled by someone knowledgeable with the contract, who can resolve issues
17. Payor assists with disputed/problem claim until it is resolved
18. Network managed their payors and holds them accountable/responsible for claims