Agenda

- The outstanding opportunity: using IT to create value
- The problems of proving ROI
- The way to measure AND realize the returns
- **The HIPAA gold mine**

Is HIPAA a gold mine?

A $500 million Integrated Delivery System can can save $6 million by accelerated reimbursement and eliminating claim write-offs and $4 million by reducing expenses every year.
KPMG paper 2001

E-transactions can save $73 billion per annum: one third of all healthcare administration costs
1994 Workgroup on EDI

$17.6 to implement $29.9b. benefits over 10 years
Department of Health & Human Services

After 2003, Care Delivery Organizations with patient accounting systems that don't provide direct 837 bill claim transactions to payers will be exposed to gross margin decreases of 10% – 15% a year until this short-coming is resolved.

Gartner Nov. 2001: HIPAA Impacts on Patient Accounting 837/835 transactions.

.....it could be

MAYO CLINIC

	Total claims paid	FTE's	Claims paid In 30 days	Claims paid In 60 days
Paper	60%	27	30%	60%
Electronic	40%	2	80%	98%

(Privacy rules are NOT considered in this presentation)

Mining the gold

Needs radical process and people changes

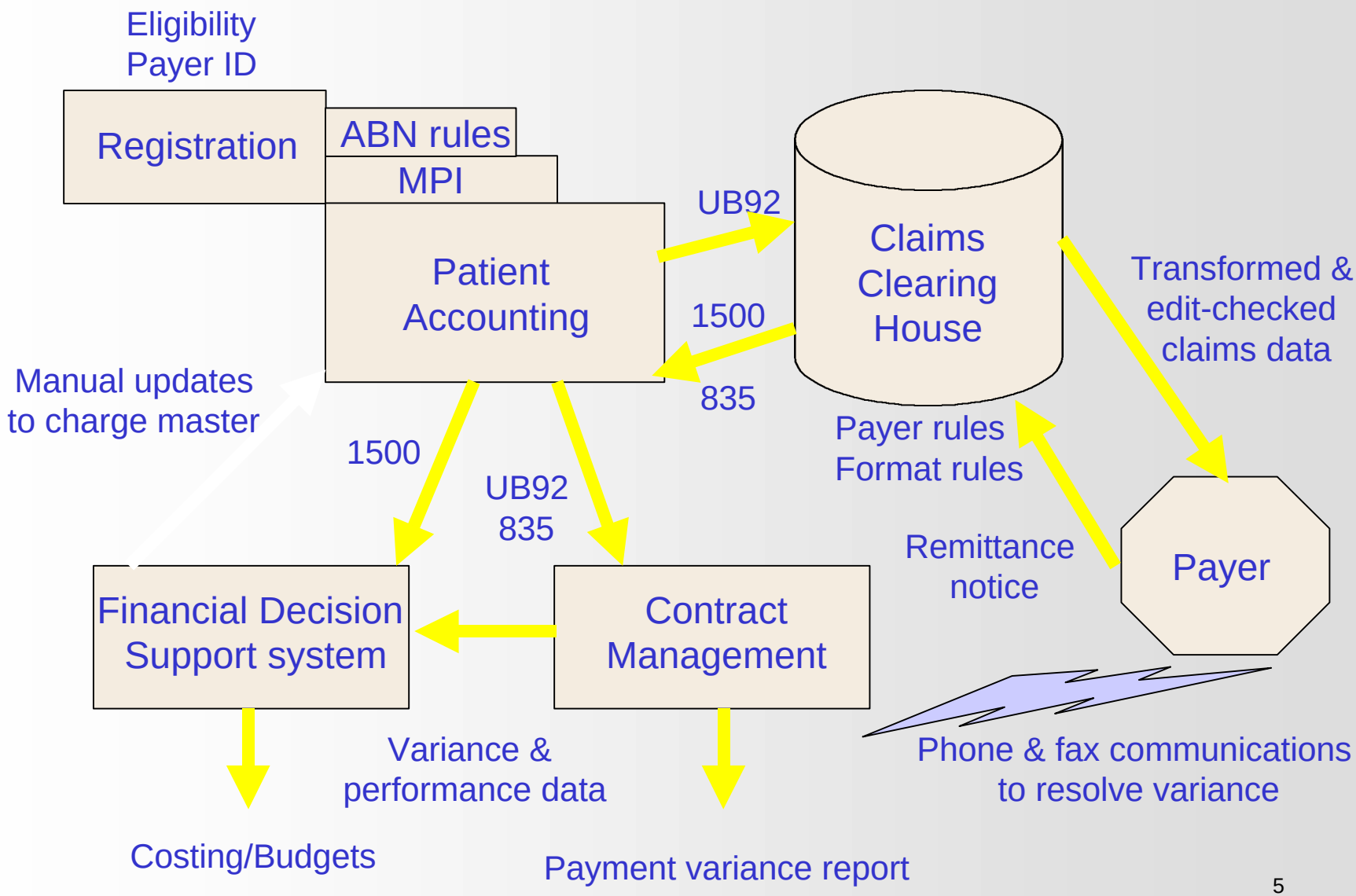
To maximize ROI, HIPAA compliance should not be pursued as a totally separate project but should be directly incorporated as part of an HCO's strategic and tactical business transformation and technology planning

The HPAA payoff – a tangible ROI. Gartner research note 3/15/01

HIPAA is NOT a compliance issue. Use it as an opportunity to:

- ❑ Reduce or eliminate on-going clearing house costs
- ❑ Eliminate expense and inefficiency of data translation between 3rd party products, clearing houses and your care application
- ❑ Reduce AR days

The current chaotic process



Mining the gold

Current systems require difficult to support interfaces especially with the clinical systems

Healthcare entities can institute same day or 24 hour turnaround service for most of their transactions
HIPAA just good e-biz. Michael Doscher for healthleaders.com 12/21/2000

Currently rules are needed in the system to determine eligibility, co-pays and ABN's are usually provided through third party systems then sent to claims speaking houses to:

- ❑ 'Scrub' for appropriate coding
- ❑ Transform – change data into payer's format
- ❑ Aggregate and electronic transport of claims to payers

The current chaotic process

Even the best performers are under- performing

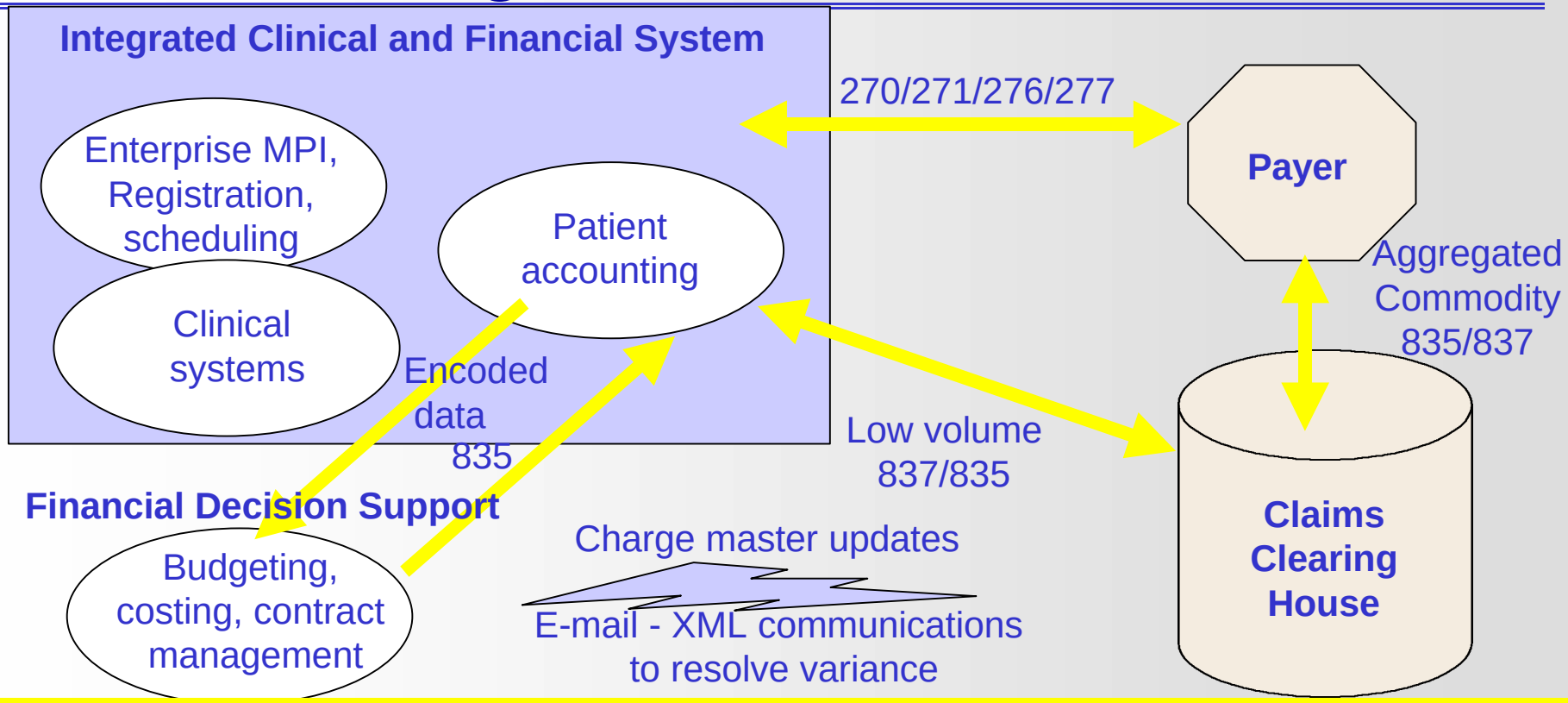
Gross days revenue outstanding	
Under 40	14%
40 to 50	55%
50 to 55	31%
Average is	44%

Year-to-date bad debt	
Under 1%	27% of hospitals
1% - 2%	27%
2% - 3%	27%
3% - 4%	18%
Average is	2% bad debt

Zimmerman & Associates best performers survey 2001

No one else even measures gross revenue!

The building blocks for the revolution



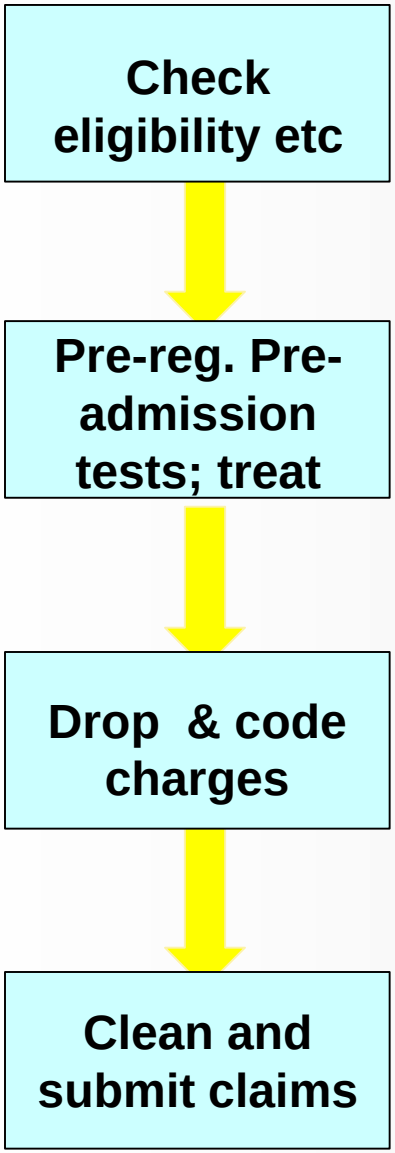
Low volume transactions will still go through clearing houses. "Consolidation of 30 – 40% of current clearing houses by 2005 (.8 probability)

"By 2005 we expect computer-based patient record applications will have matured to the point where they they generate highly-accurate encoded data from clinical documentation and order-entry applications that will be used to produce a patient bill which has been compliance checked at registration, during service delivery and just before the direct 837 is compiled".

CPR's produce data for claims attachments for supporting pre-authorization of clinical services

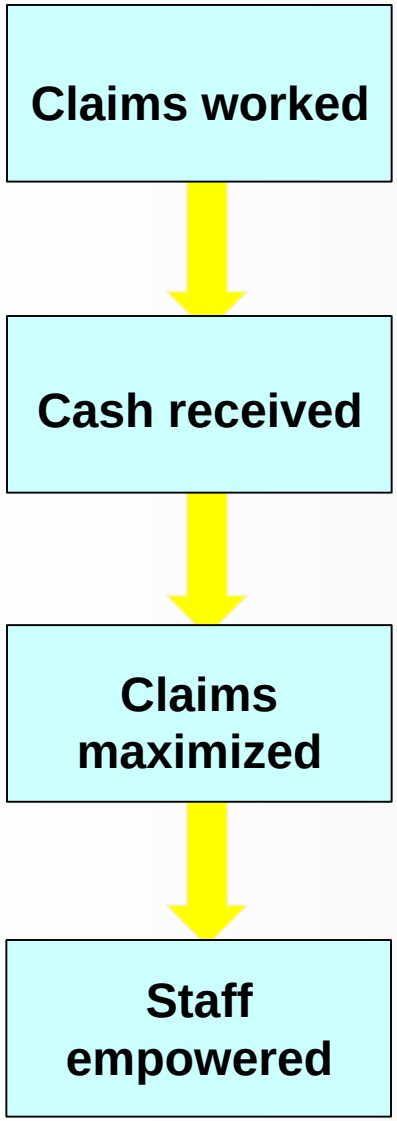
All from Gartner Revenue Cycle Management 2005 scenario. Feb. 2002

Improve the process: the way to go



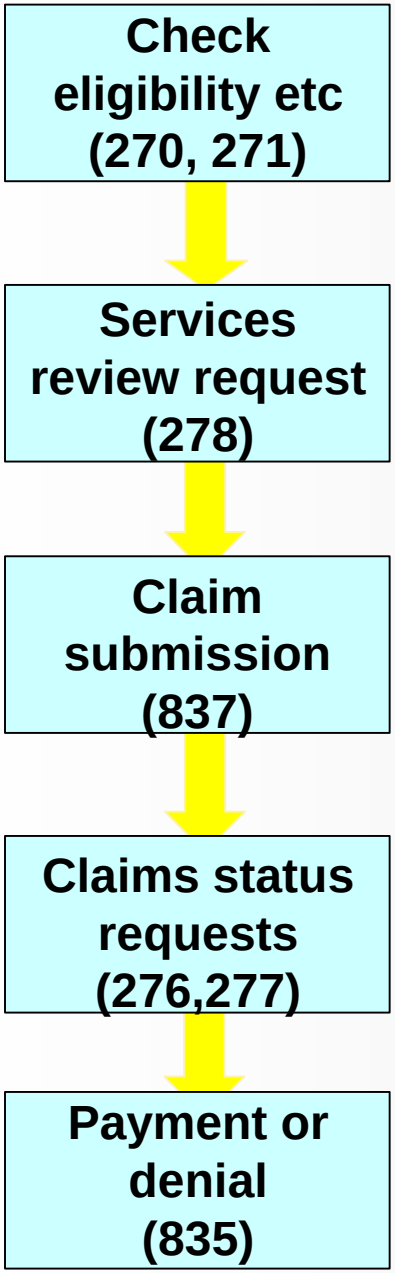
- ❑ Patient make an appointment on the Web, provider electronically checks insurance cover (270,271), & tells patient how much they will have to pay
- ❑ Provider checks coverage and obtain authorizations (278)
- ❑ Collect all demographic data before arrival
- ❑ Collect cash at point of service (Enterprise-wide MPI ensures correct identification of payers, patients and employer)
- ❑ Charges drop automatically from the clinical system
- ❑ Physician tools to collect appropriate ICD9 and CPT4 codes etc.
- ❑ Billed on day of departure (simplified bill for patient: AHA & HFMA project): bill does not need to be held for accuracy or late charges
- ❑ Claims cleaned in-house using small number of edits (rules minimized) & submitted electronically (837)
- ❑ Claims attachments automatically extracted from clinical systems and attached electronically (837)

Improve the process: the way to go



- ❑ Patient and provider access updates on claims status electronically (276,277)
- ❑ Cash received electronically (835) and banked
- ❑ Automatic submission of bill to secondary payers (835)
- ❑ Collection by phone: or through the Internet
- ❑ Virtually no use of collection agencies
- ❑ Contract management system automatically checks payments and submits additional claims
- ❑ Rate negotiations based on meeting Leapfrog standards (link to clinical system for POE volumes)
- ❑ Detailed contract history used to minimize on-going contracted rates
- ❑ All Access and Revenue staff report to the same highly-paid VP
- ❑ Individual collector performance-related pay

Estimating staff savings: HFMA study



A 350 bed hospital has 4 to 6 FTE's. Calls average 10 minutes, electronic averages 2 minutes: saving of 1.25 FTE's

Services review involves clinical, registration, financial counseling plus a nurse to get clinical data. 20 to 30 minutes per call. Saving of 2 FTE's from telephone calls only (ignores automated clinical information collection)

Hospitals submit 65% of claims electronically currently. Paper bill takes 5 to 6 minutes to review, sign and put in envelope. 30% to 35% edit rate on initial bills is typical: the billing system insurance profiles are outdated). 1 FTE saving for 350 bed hospitals

Currently all inquiries are by phone. 40% to 50% of billing office staff work in this area. With only 25% of transactions automated, save .5 FTE for Medicare, Blue Cross and Medicaid, 2 FTE for commercial payers and 3 FTE's who work on follow-up

25% to 30% are still manual. Save 1 FTE

Staff savings summary

Martin Brutscher: realizing savings from HIPAA transaction standards. For HFMA 2001

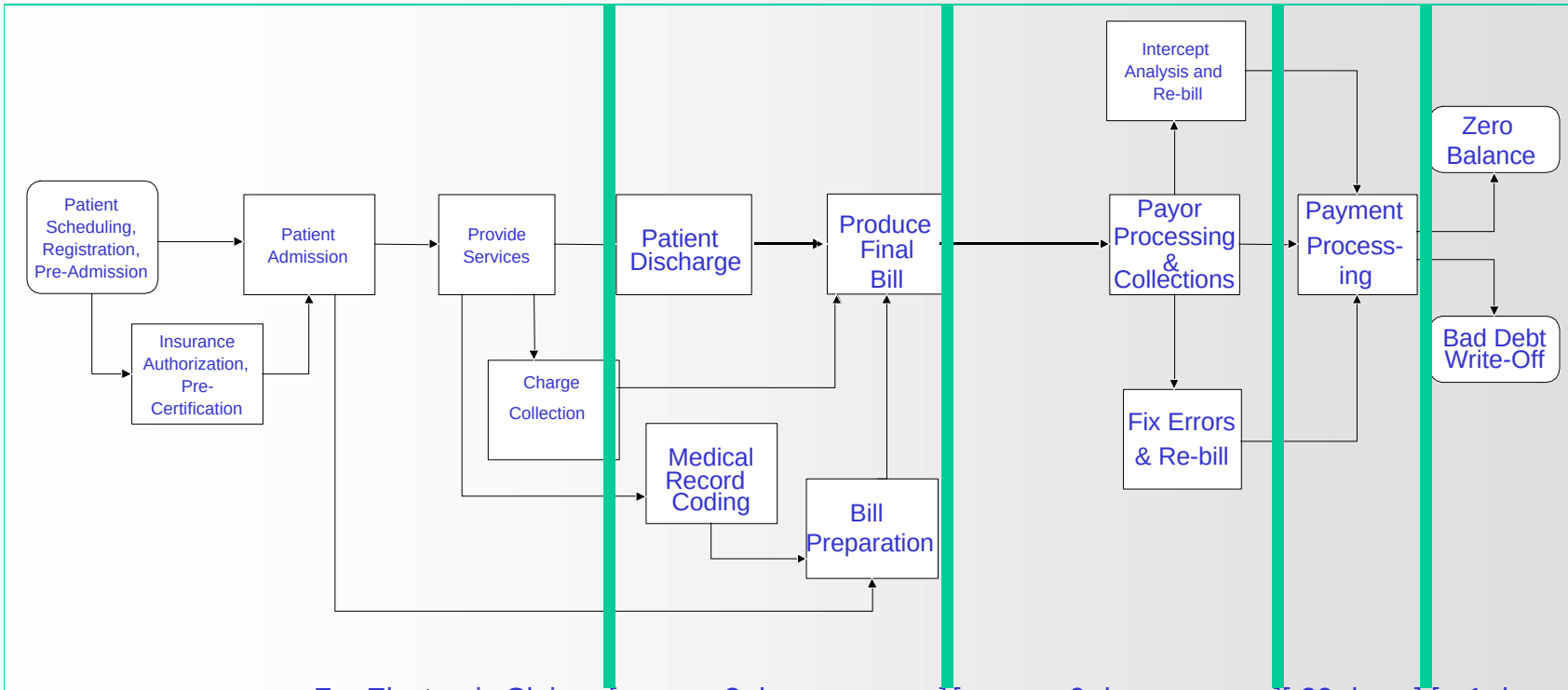
Total of 10.25 FTE savings potential in 350 bed hospitals
But 5.25 FTE's are assumed to be re-allocated to other processes: virtually NO Process Improvement or greater use of technology assumed!! Therefore staff savings estimated at $187,500 per annum.

Another gross under-estimate?

"20% to 30% of Health Information Management staff used for coding and data abstraction can be released."

Revenue Cycle Management: 2005 scenario: Gartner

Revenue cycle days savings



For Electronic Claims: [--------- 3 days ----------] [----- 0 days -----][-20 days-] [-- 1 day --] **Total days = 24**

For Paper Claims: [--------- 3 days ----------] [----- 4 days -----][-45 days-] [-- 1 day --] **Total days = 53**

AR days saving **4 days** **25 days** **Total days saved 29**

Bill hold 9 days Medicare*
8 days Other*

Total days = 64*

*3rd quarter 2001 Average HARA**

Zimmerman & Associates 2001

Best hospital total days = 32**

Revenue cycle dollar savings

	350 beds	500 beds
Annual revenue	$250 million	$350 million
One day in AR	$685,000	$1 million
Twenty-nine days in AR	$20 million	$28 million
Invested at 5% per annum	**$1 million**	**$1.4 million**

Bad debts, denials and paper savings

Saving measured	350 bed hospital	500 bed hospital
Bad debt reduction [1.]	$1,875,000	$2,625,000
Authorization denial reduction [2.]	$750,000	$1,050,000
Other cost savings [3.]	$20,000	$30,000
	$2,645,000	$3,705,000

1. 25% of bad debts result from poor pre-registration data. If the current bad debt % is 3%, it can be reduced by .75% (based on revenue of $250 million for a 350 bed hospital)

2. Average 350 bed hospital writes off $1m to $1.5m or .006% of its revenue due to authorization and timely filing issues. Can be reduced by 50% or a .003% reduction.

3. Includes paper bills and mailing of statements to patients.

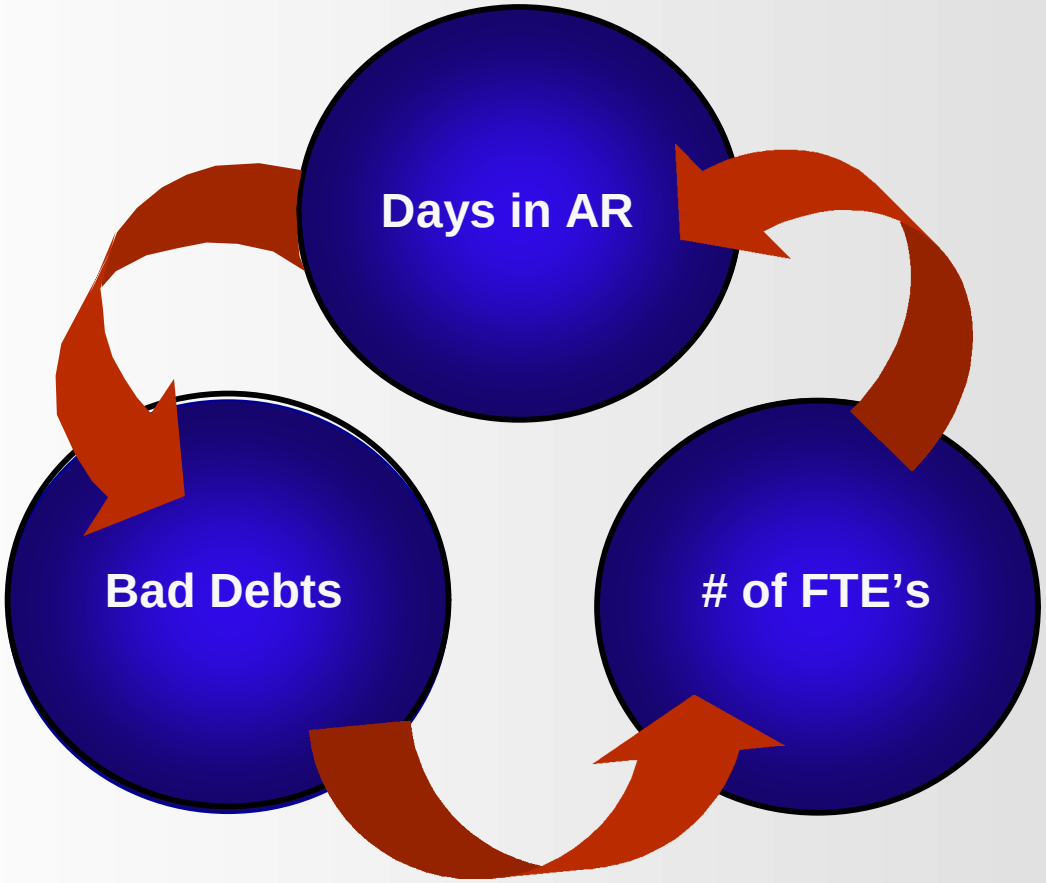
Ignores significant savings from clearing house costs, fewer out-of-network referrals + all patient satisfaction benefits including improved access, less re-scheduling etc.

These figures are very conservative: for example

Rejected claims will be reduced from 11% to 5% with a saving of $15 million in annual cash flow for a 350 bed hospital

The HPAA payoff – a tangible ROI. Gartner research note 3/15/01

Conclusion: target three KPI's.....



...and mine the gold