AKAMAI PRACTICE MANAGEMENT

Administrative Challenges with Payment Transformation
Open Letter to Hawaii Physician Organizations

From: Akamai Practice Management
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Akamai Practice Management provides practice management systems for about a third of Hawaii's independent physicians. In this role, we have become increasingly concerned with some administrative challenges associated with HMSA's PCP Payment Transformation program. We have discussed these issues with HMSA and sincerely believe they are taking action to try to address them. However, we believe it is vitally important that the physician community be unambiguously aware of these matters since they could create significant administrative impacts and potentially expose practices to liability.

These billing issues are somewhat technical in nature and haven't been adequately addressed by the POs representing Hawaii's physicians.

Background

In the early phases of payment transformation, HMSA instructed practices to bill patients and secondary payers as if the claims had been adjudicated under the old FFS arrangement. The only difference being that instead of the practice receiving payment from HMSA, the FFS amount was deemed "capitation withhold" and the practice was alternatively compensated with per-member-per-month payments. The theory was that patients or secondary payers would continue to pay the practices as they always had and the transformation process would be largely transparent to them.

Unfortunately, this isn't the case and it creates two very specific problems; one related to collecting tax and one related to collecting payments from secondary insurers.

As the problems associated with these transactions have become more evident, HMSA has stopped recommending to practices what should be done. They are refraining from providing guidance and suggesting that these issues be determined by the practice themselves.

Obviously, it isn't practical to have each practice's billers or advisors making their own interpretations of complex tax and billing regulations. Should these interpretations be at odds with those of formal authorities, the physicians could be exposed to potential liability.

Therefore we are imploring Hawaii's physician organizations to investigate these matters for their physician members and, in conjunction with HMSA, come to a consensus on the appropriate way to address them and educate Hawaii's practices so they aren't put at risk.

Issue 1: Tax Liability

In HMSA's PPO plans, patients are responsible for tax. In HMSA's parlance "tax isn't a covered benefit". Under fee-for-service, the expectation was that in addition to any copayment that was due, the patient was responsible for the tax on HMSA's eligible charge. This is either referenced, or specifically calculated, in HMSA's Report to Member, Report to Provider and electronic remittances.

As an example - under FFS if HMSA allows $200 for a particular charge and pays $180, the patient would be expected to pay the $20 difference between the allowed and the paid, plus the tax on the total; about $8 or $9 depending on whether you are on Oahu or another island. So a patient in Honolulu would owe about $29 under this scenario.

However, an underlying general principle of Hawaii's excise tax law is that no more can be collected from a consumer than the business must pay on the individual taxable transaction. Using this logic with the example above, the actual income derived from the visit is only $20 and the tax should be in range of 90 cents, not $9. It could be argued that a practice collecting tax using the original approach above, is systemically overcharging all patients from whom tax is collected.

To the best of our knowledge, up to now, virtually all PCPs in the payment transformation program have been following this same questionable approach to collecting tax. We believe this has occurred for several reasons:

- Implicit in HMSA's payment transformation program has been the concept that the entire process could be transparent to the patient.
- In the early pilot programs in Hilo (starting many years ago) and in Honolulu (April 2016) practices were specifically instructed to bill patients as if each visit had been adjudicated on a fee-for-service basis.
- Until March 1st of this year, HMSA remittances (both paper and electronic) showed individual transactions as if they had actually been paid FFS. There were simply a couple of entries at the end of each overall remittance indicating how much had been deducted in capitation withhold for all patients in total, with no breakdown by individual patient or encounter.
- A key concept of the payment transformation program was that physicians would be kept financially "whole" and, in aggregate, income would not be reduced. We believe that this promise implied that patient or secondary payer copayments would not be affected.
- The information systems that process payments and portray the tax on patient statements (including ours) haven't been modified to act any differently than they always have. At least in our case, this is because the underlying remittance details expressly indicate the specific tax amount.

It should be pointed out that the guidance from the state tax office is slightly ambiguous on this point.

A general overriding principle of Hawaii's excise tax law is that a business cannot collect from a consumer any more excise tax than the business is liable to pay on a specific transaction. State tax

bulletin 98-1 (related to tax on medical services) specifically mentions several times that the "GET cannot exceed the actual tax due on the transaction".

However, the same bulletin says that a provider "may compute the GET on the eligible charge ... and pass on the tax to you". We suspect that this latter phraseology didn't anticipate the idea that the amount of the eligible charge would not be fully paid (as is the case under capitation). But this certainly adds confusion to the matter.

HMSA has indicated to us that their legal team is looking into this situation. Once they have made their determination of what the appropriate action to take would be, they've said they will make their interpretation of the law known to the physician community. However, they are quick to accurately point out, that they are not tax advisors nor should their interpretation be inferred as a definitive ruling to drive physician tax behavior.

Therefore we feel it is incumbent on representatives of the physician community at large to do their own due diligence with respect to this issue. Because of the role POs have had in negotiating and contracting with HMSA regarding payment transformation, we feel they are the groups most appropriate to lead this effort.

Issue 2: Secondary Payers Aren't Commonly Processing Claims Appropriately

Beginning on March 1 of this year, HMSA revised their remittances to reflect each of the actual capitated transactions under payment transformation. This is critical, since under HIPAA regulations, secondary electronic claims must indicate how much the primary payer allowed and paid.

As mentioned above, up until March, remittance information for any individual encounter looked no different than if the claim had been adjudicated on a FFS basis. Using the example above, the older remittance format would have indicated that HMSA actually paid $180 on the $200 eligible charge, even though no payment was made.

We felt the pre-March remittance approach had the potential to create liability, when claims filed to secondary payers (in particular governmental programs) falsely indicated how much the practice had been paid by HMSA as primary. We were pleased to see HMSA's March change.

We believe HMSA's new remittance format is accurate. Unlike the prior remittance, it appropriately reflects the nature of the financial transaction. It shows how much was originally billed, how much was adjusted to reflect HMSA's allowed amount, how much HMSA actually paid (if anything) and how much was adjusted as capitation withhold.

Unfortunately, it appears that the claims adjudication systems of secondary payers frequently don't know how to recognize the capitation adjustment, especially when the secondary claims are filed electronically. We believe this is because HMSA's payment transformation program is so unique and innovative, there isn't precedent for this type of transaction elsewhere in the country. Consequently, payer adjudication systems aren't currently configured to properly handle these secondary claims.

Although our sample size is still small, we have yet to see a payer appropriately pay an electronic claim that is secondary to an HMSA claim adjudicated after March 1st under payment transformation. This is particularly critical with respect to traditional Medicare, which mandates that all claims be submitted electronically for most practices.

It seems many secondary plans are paying as if HMSA allowed the full amount on a FFS basis but paid nothing. This leads to overpayment by the secondary payer.

The consequences of this are significant. There can be liability exposure if the overpaid amounts are not refunded. Straightening this out is an enormous administrative burden where the overpaid transaction needs to be identified, the secondary payer notified of the over-payment, a refund or takeback arranged (typically this will involve taking back the entire original paid amount and a requirement to generate a new claim with hopes they get it right the second time) and appropriate offsetting manual transactions entered into the accounting system. We estimate that it could take 30 to 45 minutes of administrative time to correct each of these overpayments.

The success of paper secondary claims seems better, although not perfect, and can be inconsistent even from the same payer. This seems to validate our presumption that paper secondary claims are more subject to manual scrutiny and therefore two similar claims may be arbitrarily adjudicated differently depending on who is doing the review.

To put the volume of this issue in perspective, we did a sampling of Akamai's clients and found that in approximately 1.3 million claims submitted in the last year, 5.2% of all claims fall into this problematic category; that is, primary HMSA with some type of secondary insurance payer. At 30 minutes per transaction, if half of these needed to be manually fixed, the cumulative administrative burden of resolving this problem, just for the 280 or so practices that we analyzed, would be about 17,000 hours of staff time; on average a bit more than 60 hours per practice per year.

Unfortunately, unlike the tax issue, we don't see any clear immediate path of resolution for this problem. Our understanding is that HMSA is researching whether they can use an alternative code to reflect that capitation withhold amount on their remittances. However, HIPAA regulations limit the spectrum of codes that can be legally used on claims. It is possible, and we fear likely, that a code may not exist that both reflects HMSA's capitation adjustment and is recognized by the adjudication systems used by third-party payers nationwide.

In the short term, filing secondary claims on paper whenever possible may be the best solution, although this brings its own set of inefficiencies and additional costs. And of course, this doesn't address the underlying issue.

We strongly encourage Hawaii's physician organizations to work as quickly as possible with HMSA to create a plan of action for how this may be addressed at the office level and educate the physician members of the POs about the recommended approach.

Akamai Practice Management

We want to assert, in no uncertain terms, that we are not experts in tax matters. We program our software to comply with regulations, but are not experts in their interpretation. The perceptions

expressed in this letter are ours alone and I expect they have been heavily influenced by conversations we have had with clients using our software in their offices, as well as our direct experience associated with running our billing operation. I suspect that HMSA, your organization and many doctors may have different perspectives.

The purpose of this letter is not to assert that our perspectives on these matters are necessarily the correct ones. It is to implore the participants in this game to come together and agree on the single set of rules that everyone should be playing by. We feel that there currently isn't a common understanding and physicians are being asked to interpret these matters themselves; a situation that is neither practical nor fair to them.

A day doesn't go by that we aren't asked about these matters and the frequency is increasing. This is a clear indication that the physician community is becoming more aware of these challenges and is perplexed about how they should proceed.

At Akamai we are more than willing to discuss these matters at length should there be questions, or if we can assist in any way. In the event that we need to modify the behavior of our systems to comply with a commonly agreed upon approach, we would obviously do so. However, we really can't be in a position of unilaterally making program changes regarding the issues discussed in this letter, without knowing that it is the consensus of the community at large.

We look forward to working with HMSA as well as your organization and its members to address these concerns going forward.

Best regards,

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