FINANCIAL PERFORMANCE

ProfitStars®

The Right Prescription for Managing Credit Risk with Healthcare Accounts

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Contents

Overview

Considering the current scope of the healthcare market in the U.S., financial institutions are beginning to realize that this area of specialty finance is becoming a significant opportunity for commercial lending units. Healthcare represents almost 18% of U.S. Gross Domestic Product (GDP), and it is growing across the country. As the industry approaches $3.3 trillion, financial institutions are beginning to educate their lenders regarding the nuances and regulations associated with this market sector. Financing opportunities cover the entire spectrum of lending from Commercial Real Estate (CRE) and Commercial and Industrial (C&I) to private, consumer, and mortgage banking. Within the C&I lending space, credit officers are beginning to see significant opportunities for revolving lines of credit, equipment financing, and owner-occupied real estate.

The lending opportunities become even more significant when you consider that healthcare expertise extends beyond just medical practitioners. Countless support businesses, including medical staffing, medical transportation, durable medical equipment, home health, IV infusion, physical therapy, pharmacy, and many more, are increasing the demand for financial services. (The market scope is highlighted in greater detail in our white paper, *The 2017 Financial Institution Guide to U.S. Healthcare*.) The purpose of this companion white paper is to begin defining the key risk factors financial institutions must consider when financing working capital assets in this market. From the smallest community banks to the largest, most want to explore opportunities in the sector, but they must first take the time to understand the regulatory and commercial risk associated with doing so.

This paper identifies seven areas of risk that each institution should evaluate as they plan and deploy working capital financing services within the healthcare marketplace. Some or all of these factors may apply to your situation, depending of the scope of services you are deploying.

7 Key Risk Factors Associated with Healthcare Accounts

1. Claim Values/Reimbursement Rates

Perhaps the most significant risk when financing healthcare accounts is the risk of overadvance or underadvance. After all, healthcare claims are not anything like traditional commercial invoices. The large majority of claims are owed by insurance companies or government agencies rather than individuals, which will be covered later. These third-party payers have contracts with each medical provider to pay claims based on a pre-defined reimbursement rate schedule. For the financial institution, this means that an invoice or claims for $1,000 rarely is reimbursed at the $1,000 rate. The reimbursement rate can vary widely depending on the payer and the type of medical product or service offered. It is not uncommon for claims to be reimbursed at rates as low as 40 - 60% of the original gross value. This means that any financial institution seeking to finance the underlying claims must do its homework to determine an appropriate advance rate prior to deploying funds.

The best way to calculate an appropriate advance rate is to look at a historical reimbursement analysis. This assessment should start at the payer level, since one insurance company will differ from another, which will also differ from government payers such as Medicare. It is also critical that your system track changes to reimbursement rates during the life of your lending relationship, since they do change.

In addition to determining the appropriate advance rate by payer, your organization should also consider eligibility of the claims being financed. For example, if claims become ineligible for financing after 90 or 120 days, you need to determine what percentage of claims are likely to be repaid during that time period, before being submitted to secondary or tertiary insurance companies. The medical provider may tell you that they are reimbursed at a rate of 60%, but if it takes 180 days to reach that rate, you need to know what their reimbursement rate is at 120 days, or whatever your criteria is for eligibility. The schedule below shows an example. In the example, the financial institution established eligibility at 120 days or less, so they would not want to advance more than 51% of total gross charges – even though the provider eventually collects more than 60%.

Payer Class	Gross Charges	Payments @ 120	120 Collection Rate	Total Collection Rate
Medicare	11,760,667	5,863,868	49.86%	57.01%
Medicaid	2,357,714	1,153,865	48.94%	59.87%
BCBS	1,324,597	991,858	74.88%	75.97%
Commercial	1,229,096	562,925	45.80%	59.71%
Grand Total	16,672,073	8,572,516	51.42%	60.53%

2. Payer Mix

In the above example, the financial institution would want to go one step further when determining an appropriate advance rate. If the lender were to establish an advance rate of 51%, they could still end up in an over- or underadvance situation given the mix of payers involved. In the above scenario, Medicare represents the highest concentration of claims, but that number will likely shift. For this reason, lenders should be more granular when determining advance rates. They should establish an advance structure that is specific to the payer, not the provider. Their financing system should also be able to track historical reimbursements by payer to reveal how closely the actual claims payment experience is aligned with the advance rates.

In addition to determining advance rates, the lender should consider the financial strength of the payer. For example, several state Medicaid programs have suffered in recent years, often resulting in payment cycles that were well beyond what the financial institution would consider acceptable for financing. For this reason, it is not uncommon to determine that some payers are simply ineligible for financing.

3. Code Diversification

In addition to the payer mix associated with any given portfolio of accounts, the financial institution should understand how many unique procedural codes (ICD-10-PCS) a provider is billing. Since the reimbursement rate schedules are determined at the code level, changes to a specific code can dramatically impact the overall advance rate of a provider's working capital facility. Providers who are billing a wider range of codes are less concentrated than those who may only be billing one or two codes through their service. An ambulatory service company, for example, may be billing less than twenty ICD-10 codes, while a medical device company may have hundreds of different codes represented in their business.

In order to understand the specific mix of codes being billed by your provider/borrower, it is recommended that you work with a third-party service provider who can run a reimbursement analysis for you prior to funding and upon annual review of the lending relationship. Such a review could include a payer mix and reimbursement analysis, an analysis of ICD-10 codes, and a general assessment of how efficiently the provider is billing claims. For example, is there significant evidence of re-billing, meaning that there were deficiencies in the original claim? This provides insight to the overall backroom operation of the provider.

4. Government Insurance Receivables

Effective underwriting of any medical provider should include a determination as to whether your institution would allow funding of government program receivables. While you can file a lien on such accounts, there are specific rules regarding the direction of payments. You cannot redirect payments from government claims away from the medical provider. For this reason, most financial institutions segment government program receivables through a provider-owned P.O. Box or ACH address, taking an assignment of proceeds once payment reaches those accounts. Pay down on the line of credit is then facilitated through a controlled sweep account to the financial institution.

It is also important to address the issue of government program receivables in your documentation, as will be discussed later. If using a standard Note & Security Agreement to document your line, you can add language through an addendum to that note to address healthcare specific issues.

There is one final point to consider when discussing government program receivables. In some cases, a government entity such as Medicare could retroactively adjust their reimbursement rate for a specific code. This can directly impact your client, causing them to adjust prior earnings. This also impacts your advance structure. For this reason, you may choose to cushion your advance rate by lowering the funds advance to accommodate such risk.

5. HIPAA and HITECH Compliance

Before initiating any working capital financing relationship with a provider of medical products or services, your institution should evaluate when and where employees could be exposed to protected health information (PHI). In simple terms, PHI is any information regarding the health status of a patient or regarding any provision of services or payment for services. This information is created by a "covered entity" or the "business associate" of a covered entity as defined within the Health Insurance Portability and Accountability Act of 1996 or the Health Information Technology for Economic and Clinical Health Act of 2009.

In most cases, it is possible for your institution to limit access to PHI by stripping it from your data files before it enters your financing system. Still, your employees could be exposed to PHI through payment processes associated with your working capital lines. For example, if the payers are remitting payment to a P.O. Box, they are likely including the explanation of benefit (EOB) with the check. The Explanation of Benefits (EOB) would include PHI. The following list from the Electronic Healthcare Network Accreditation Commission provides a set of steps to consider as you structure your processes for financing.

1. Determine eligible current or planned services and the financial institution's status as a covered entity or business associate under the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).
2. Set-up the infrastructure to successfully achieve compliance. This task includes the selection of a corporate-level program sponsor as well as a privacy officer and a security officer. These roles may be assumed by one or more individuals.
3. Conduct a risk analysis.
4. Conduct a risk audit and identify controls or control gaps.
5. Review and update technology systems as needed.
6. Develop a communications plan.
7. Update workforce training.
8. Consider data privacy and security accreditation or certification by an independent third-party such as the Electronic Healthcare Network Accreditation Commission (EHNAC) or the Healthcare Information and Management Systems Society (HIMSS).

Source: https://www.ehnac.org/wp-content/uploads/2013/07/FI_Compliance_Guidelines-08102012_Update.pdf

6. Documentation and Terminology

As mentioned earlier, your documentation for a revolving credit line will need to include more than simply a Note & Security Agreement. Most institutions will want to address specific issues such as the advance rate schedule, claim eligibility, and the presence of government program receivables through the use of an addendum to your note. As the "business associate" of your provider/borrower under HIPAA, you will also need to execute a Business Associate Agreement. If you are using a third-party vendor service to facilitate financing, that vendor may already provide templates for such documentation. Otherwise, your legal counsel may need to draft them for use in the financing arrangement. Either way, your counsel should be familiar with, and have reviewed, any documentation that supports your primary Note & Security Agreement.

In addition to the documents mentioned above, your counsel should review how to describe collateral assets within the UCC Financing Statement. They may choose to specifically refer to "healthcare insurance receivables" or other terms, depending on their preference or with regard to specific State or Federal guidelines. There may also be specific documents needed to address the use of a controlled sweep account or lockbox procedures.

Beyond just the closing documents, your financial institution should determine whether changes need to be made to your underwriting templates or your internal credit policy to address issues specific to the healthcare sector.

7. Patient Pay Accounts

When it comes to healthcare insurance receivables, patient pay accounts are a totally different animal from insurance accounts. In many cases, patient accounts are placed on extended payment terms by the facility. In other cases, they experience a high rate of default. A McKinsey study estimated that about 68% of bad debt within hospitals comes from self-pay and uninsured claims.

Due to high default rates, most working capital advance structures exclude patient accounts. Most financial institutions are not equipped to accommodate default rates that can range from 20% to over 50% depending on the nature of the claims and whether the service was uninsured or represents the balance after insurance (BAI). That said, there are specific products that can facilitate funding of these receivables. Most resemble consumer loan structures, where the patient has been offered a term loan structure to pay the BAI on their medical procedures. One thing is for sure – self-pay accounts are on the rise. As employers migrate to high deductible plans and healthcare costs rise, the patients will carry an increasing share of the responsibility. This will likely lead to an increased need for facilities such as hospitals to shift these loans off their books through financial institution programs.

As revealed in our previous publications, the demand for working capital financing in the healthcare sector is expected to rise as the industry expands. Growth rates are currently forecasted at 6% annually between now and 2025, being driven by increased cost of service and by increased demand for those services across the board. We fully expect medical providers to seek financing from their financial institutions. Hopefully a review of these seven key risk factors has allowed you to begin assessing future offerings from your organization. Due to the complexities of the market sector, we anticipate that most financial institutions will seek third-party vendors for technology and market expertise.

Source: http://healthcare.mckinsey.com/sites/default/files/793544_Hospital_Revenue_Cycle_Operations.pdf

We encourage you to speak with one of our lending sales executives today and learn how ProfitStars can expand your opportunities in the healthcare sector with our Healthcare Lending solution.