



PayerView 2016

Disclaimer and Methodology

athenahealth, Inc.

Published: May 2016

Introduction

PayerView® is athenahealth's annual review of the performance of the largest payers in our network. PayerView ranks payers based on their performance scores on eight administrative, transactional, and financial metrics.

This document does the following: (1.) it describes the conditions and limitations to which the use of the PayerView website is subject; and (2.) it details the methodology that athenahealth uses to determine results and payer rankings for PayerView 2016.

To learn more about PayerView or to see the 2016 results, visit: ATHENAHEALTH.COM/PAYERVIEW

Disclaimer

Use of the PayerView website operated by athenahealth is subject to the following conditions and limitations. The data provided is based solely on actual claims activity captured in the athenaNet® system and represents a limited set of physicians and payers. We have not included information with respect to payers where we have not collected the volume of data in the relevant period that exceeds that thresholds listed on this site.

The materials on the site have been prepared for informational purposes only and do not constitute legal, financial, or business advice. This information should be viewed critically, and should not be assumed to be representative of our experience going forward, or of the experience of physician practices that do not participate in our services. Because of the possibility of human and mechanical errors as well as other factors, athenahealth makes no representations or warranties, expressed or implied, regarding the accuracy, timeliness, adequacy, completeness, legality, reliability or usefulness of any information on the site and cannot be responsible or liable for any errors or omissions in its information or the results obtained from the use of such information.

We report these data as we have found them in our system under the parameters that we describe. The ratings provided on the website are statements of opinion and not statements of fact or recommendations to utilize any particular provider's services and do not constitute consumer or business advice. We make no representation and do not assert that the data are statistically relevant for any given payer or for payers as a whole or that they are indicative of anything other than the direct experience that we have observed in the relevant time period. Users are solely responsible for determining whether the information is suitable for their purposes, and reliance on the information is at the users' sole risk.

Users should obtain any additional information necessary to make an informed decision. athenahealth accepts no responsibility for the use of the site, or for the consequences of any actions taken on the basis of the information provided. Users of information from this site do so on an "as is" basis. This disclaimer applies to both isolated and aggregate uses of the information. Changes may be periodically made to the information herein; these changes may or may not be incorporated in any new version of the website.

Methodology

PayerView® is athenahealth's annual review of the performance of the largest payers in our network. PayerView ranks payers based on their performance scores on eight administrative, transactional, and financial metrics. A payer's overall score is calculated as a weighted average of its rankings on those eight individual metrics.

Payer definition

athenahealth defines a "payer" as an organization to which a provider submits a claim in order to get paid. This includes a managed care organization, health insurer, military health plan, HMO, preferred provider organization, third party administrator, Medicare/Medicaid plan, and carrier or intermediary to whom physicians submit third party payment claims. Some of these organizations may be forwarding claims to others for actual adjudication, processing, payment or other important steps in the payment process.

All of the data reflected on this site are derived from the experience of athenahealth and its clients using athenahealth's claims submission, tracking, and follow-up services. The data represent experience during the data collection period by and

on behalf of athenahealth physician clients in transactions with the payers listed and/or in transactions on the claims submitted to the payers listed. The rankings and data presented do not and are not intended to present or ascribe causes for that experience, and "performance" is intended to refer to measure of observed results when claims were submitted using our services to a payer.

As noted above, the activity of a given payer may vary depending on the role that it assumes in the claim process; and, PayerView data results for a given payer may be caused in whole or in part by the actions or processes of others, including other payers, with whom or for whom the payer in turn conducts business. Similarly, the measures chosen for performance are affected by time lags, mistakes, processing practices and data quality on the part of the physician practices involved, by athenahealth itself and by third parties who act as intermediaries in the transmission of claims information. In some cases, such intermediaries are specified or approved by the payer; and, in other cases they may be chosen by other intermediaries or by athenahealth and may be outside of payer control. We actively work to identify and to address matters that we or our customers can control that affect these and other measures, and we have adopted processes that differ from others in the industry. The performance metrics experienced with the same payers by other physicians using other services may have differed materially for the data collection period.

Inclusion/Exclusion Criteria

Payers were included or excluded from the PayerView sample based on the inclusion and exclusion criteria noted below for the measurement period of calendar year 2015 (January 1, 2015 to December 31, 2015).

Inclusions

- A minimum of six clients must submit to any given payer per quarter in order for the payer to be included in PayerView. These clients must be live on athenaNET for more than 90 days for claim volume to be included.
- Payer must meet a minimum claim volume threshold of 10,000 claims per quarter for the four quarters of calendar year 2015.
- Payer must receive claims from athena providers for more than half of the calendar year (6 months) starting in January 2015.

Exclusions

- A payer is excluded if unique issues impact that payer, region, or high volume practice. For example, if one practice represents over 50% of the claim volume for a payer, then this payer is excluded.
- IPAs and Workers Comp are excluded.

214 payers met the inclusion criteria for calendar year 2015 and were included in PayerView 2016.

Metrics

The eight metrics included in PayerView for 2016 are described below:

1. Days in Accounts Receivable (DAR)

Average length of time it takes to receive payment as measured from the date of charge entry to the date of remittance post. PayerView's DAR measures cash flow by dividing the average dollars outstanding by the average daily charge. This measurement encompasses the period from the day a charge is entered into athenaNet to the day payment for a charge is posted. This includes any lag time that was caused by athenahealth or its clients in the transmission and posting process. This lag time is one of several ways this metric could have been influenced by matters outside the control of the payer. However, we believe that claim submission and posting procedures tend to impact the outcome consistently across payers, making data useful.

2. First Pass Resolve Rate (FPR)

Percent of claims that are successfully resolved on the initial submission (e.g., paid or transferred to patient responsibility). "First Pass Resolved" claims are classified as receiving full or partial payment and/or deemed as patient responsibility by the payer on the initial claim submission. Partial payments count as a positive outcome only if the payer communicates that no outstanding amount is remaining. Because athenahealth's client base is a subset of the national provider base, these figures may differ from the national average.

3. Provider Collection Burden (PCB)

Percent of charges transferred from the primary insurer to the next responsible party. Includes co-insurance, deductibles and other transfers (e.g., non-covered services). Co-pays and Real Time Adjudication (RTA) amounts are not included in the rate as this information is readily known at the time of service. A shift in financial burden is imposed on providers when they become responsible for managing collections from the next responsible party after the time of service. Given that providers have few point-of-service tools to manage this growing segment of their revenue stream, it is important to measure what percentage of amount owed is only available after a patient's visit and requires providers to incur additional costs to collect those payments.

4. Denial Rate

Percent of claims (both pended and denied) that require the practice to perform back-end rework. The more rework involved with a claim, the longer it takes for the provider to get paid and the greater the resources required by physicians to arrange payment. To measure the frequency of these events, PayerView calculates the number of outright denials for claims submitted to each payer, as well as the line items that require reworking. Because we define denials in this calculation as all claims requiring back-end work, this metric may include claims at the payer pending additional information. Moreover, since back-end work is applied by physicians or by athenahealth, there may be subjective factors that affect this percentage. However, we believe these factors tend to impact the outcome consistently across payers.

5. Enrollment Efficiency

Quantitative ranking of administrative burden surrounding provider enrollment in electronic transactions. Ranking considers quantitative scores for enrollment in EDI, ERA, EFT, & PAYTO. Scores assigned based on enrollment type, signature requirements, and submission method.

6. ERA Transparency

Percentage of electronic remittance advice (ANSI 835) denial messages with actionable explanations and clear next steps. This metric reflects how well the payer has adopted the standard code set by returning clear adjustment reason codes accompanied by remark codes as appropriate. The inclusion of the ERA metric, along with the Eligibility Accuracy metric, brings more visibility to the full HIPAA covered ANSI standard transaction suite.

7. Eligibility Accuracy

Correlation of eligibility response to adjudication outcome. Measures how well the payer's eligibility transaction predicts the outcome of a claim. Note that PayerView does not measure the amount of money practices receive from payers; it quantifies, rather, the challenges practices face when collecting from payers for services. Eligibility transactions are most effective and useful to providers when they are available (i.e., do not encounter persistent downtime or unverified patient responses) and reliable (i.e., the eligibility response indicates how we can expect the claim to be adjudicated). It is important for payers to return a reliable and detailed eligibility response so that providers can identify and resolve eligibility related issues before submitting the claim to the payer.

8. Benefit Reliability

Percent of patient responsibilities in which payer returned the correct patient responsibility information through eligibility at the time of service. For copays, this means having an exact match to the eventual copay amount. For deductible or coinsurance, it is only required that the eligibility response indicate that the patient may owe a deductible or coinsurance.

Note: Some payers do not have scores for benefit reliability. To calculate the benefit reliability (BR) metric, payers must have a transaction thresholds of 1,000 transactions per quarter. Payers not meeting this BR volume are assigned the median BR score in order to be ranked.

Metric Weighting

Each metric is assigned a weight which is used to calculate a payer's overall ranking. Metrics are weighted to contribute to an overall payer score and ultimate ranking. These weights are designed to ensure no one metric contributes disproportionately to the overall score. Metric weighting is occasionally adjusted.

Weighting for 2016 and for the years prior is shown below:

Metric	Weighting				
	2012	2013	2014	2015	2016
YEAR					
DAR	25%	20%	20%	20%	20%
FPR	25%	20%	20%	15%	15%
Provider Collection Burden	10%	15%	10%	10%	10%
TOTAL Financial Performance	60%	55%	50%	45%	45%
Denial Rate	20%	15%	15%	15%	15%
Enrollment Efficiency	N/A	0%	5%	5%	10%
Enrollment TAT	N/A	N/A	0%	5%	N/A
TOTAL Administrative Performance	20%	15%	20%	25%	25%
ERA Transparency	10%	15%	10%	10%	10%
Eligibility Accuracy	10%	15%	10%	10%	10%
Benefit Reliability	N/A	0%	10%	10%	10%
TOTAL Transaction Efficiency	20%	30%	30%	30%	30%

Changes for 2016

- An important change to PayerView this year was made in terms of how the metrics were aggregated together to create a payer's final score. This year, a payer's overall position was determined as a weighted average of their ranks on the individual metrics. This is a simplification of the aggregation process used in past years, which involved normalizing and combining the weighted metric values.
- In 2016 the Enrollment TAT metric, which was included in last year's analysis, was removed. To account for this, the Enrollment Efficiency metric's weighting was adjusted from 5% to 10%. The remaining seven metrics appeared in PayerView in previous years (2013-2015).
- The Enrollment Efficiency metric was adjusted to take into account new methods of possible provider enrollment and the appropriate burden of those methods.
- The Eligibility Accuracy metric was adjusted to ensure that payers were being properly assessed for what other payer's returned on their eligibility responses.

Analysis

A payer's overall score is calculated as a weighted average of its rankings on the eight individual metrics described above. The 214 payers included for 2016 are then ranked by overall score - a lower score indicates a better performance and hence a better overall ranking.