Hello, my name is Erika Brown and I am the Director of Patient Accounts for the Community Health Centers, the Federally Qualified Health Center serving Chittenden and southern Grand Isle counties.

I'd like to thank all of you for being here today to hear more about our important work, especially related to processing claims.

As a quick background, the Community Health Centers has been around since 1971, understanding and addressing the needs of our community members regardless of financial status or life circumstance.

We currently care for 32,000 patients, providing medical, dental, counseling and psychiatry services – among many other specialized safety net programs like our homeless healthcare program.

On Average we have about 135K encounters per year.
In a years' time, we submit an average of 178K primary claims alone per year. BCBS being our largest Commercial payer.

We do our best to give comprehensive care to patients and part of that is recognizing the many social determinants that our patients face. In a climate where access to care is already and issue, we do our best to meet patients needs. Delays in payments for any visits cause significant payment delays for our health center.

The changes in claim processing has had a negative impact in not receiving payments for services we rendered and or has delayed payments significantly, increased administrative burden for all coding and billing, and has delays bills to patients. We have lost staff due to the stress of payments obstacles, delays and insurance processes that are not consistent, sustainable, or often are not working. This process are adding cost and taxing the healthcare system overall.

COTIVITI denials/administrative burden and Patient impact:

- Access to care:
  CHC is one of a few, if not the only practice in Chittenden county currently accepting new patients. We are continuing to absorb the delay or lack of payment however this does affect our bottom line when rendering for services that we may not get payment for 60/90+ days or at all if the review returns denied and needs an appeal.

- Delayed patient statements (especially those with deductibles and co-insurance):
  It can take up to 30 days for the chart notes to be reviewed when it's a BCBS VT plan and up to 60 days for an out of state BC plan. If denied we can submit for another review substantiating the rationale as to why this met coding guidelines for payment. Over all, this delay in payment also affects patients, especially those who have a deductible plan and will not get a final bill until this process is compete and the payer sends the EOB noting the patient balance.

Provider/staff burnout:

- Provider burnout:
  Primary care providers provide a cost savings to payers and keep the ER usage secured for necessary services. If primary care providers continue to be burdened with administrative tasks, access to care may be a bigger issue and could result in patients visiting the ER instead of having an office visit with their PCP at a fraction of the cost. Without access to PCP care, providers cannot enact care coordination and management to better manage patients care and services in order to avoid unnecessary medical spend.

- We have experienced additional staff turn over specifically due to the administrative burden and stress to keep up with this workload. Our commercial biller with 15+ years experience has resigned as of last month and has completely left healthcare.

- We have had the need to designate multiple staff/coders to attend to these denials specifically which is taking them away from other necessary reviews.

Provider/Health Center impact

- Delayed payment of 60/90+ days beyond the standard 30 days post DOS.
- If appeal is needed this delay in payment gets extended beyond 60/90 days and requires additional documentation from the provider office.
- The appeal is reviewed by the payers COTIVITI or denial team and if it's denied, there is no other action even if the decision is felt incorrect per coding guidelines. In this scenario, there is concern of subjectiveness in denials and payments.
- The time to manage the administrative ask for these denied claims is extensive. The process of gathering of chart notes and other associated documents, emailing them to the designated email address, waiting for the response, tracking these via a spreadsheet with continued follow-up. Since the decisions do not always get returned, this causes another round of email requests and at times resubmissions starting the process over again.
- Delayed bills to patients due to the above which adds further delay in payments to the health center.
- Inability to reach the call center. This COTIVITI denial process was rolled out while BCBS's hold times are still at a 2+hours. The email options that were provided as an alternative often result in not being received due to a BCBS email issue or the BCBS reps managing these emails are behind and so are not responding timely. This is cause for further tracking, delay in payment and leaves the provider office in a continuous loop of emails. We wait 30 days after emailing, follow-up and often need to resend emails, wait for response again and once we have guidance take action as needed in order to be paid.
- The 2+ hour hold times and inability to reach the call center also delays us in getting answers for patients regarding some of their questions. This is frustrating for patients.

We continue to care for our patients however in a climate where margins are already slim, this additional work to gain payment for services rendered is unfavorable for all. The payer who has to generate and send weekly detailed denial reports to each primary care office and has to complete manual review, patients for access of care and delayed bills and the health center to carry such a large administrative task and wait up to 90 days or more for payment.

Thank you for your time. Please feel free to reach out to me any time with questions.