“THE FAST AND THE FURIOUS”
Revenue Cycle – 3.0

HFMA Arkansas Fall Conference –
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Jorge Fernandez, Business
Development Principal
Availity Hospital Solutions Division

HFMA Lone Star Chapter Secretary,
Membership & Program Committees,
& HFMA 2.0 Education Task Force
Committee

FAST & FURIOUS – IRMA
Vaginal Delivery in 1960 cost $230.05

Actual Cost for a Vaginal Delivery in 2017

$9,802 in 2017
$230.05 in 1960

Vaginal Delivery should cost approximately $1,800 today
"WE HAVE MET THE ENEMY AND THE ENEMY IS US,"
Sept 10, 1813 after the Battle of Lake Erie
Famous Naval Quote by Commodore Oliver Perry

Data shows how most of healthcare’s inflation has resulted from increased administrative spending

*2300% increase in U.S. healthcare spending per capita between 1970-2009
Source: Health Care Costs: A Primer, The Henry J. Kaiser Family Foundation

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“WE HAVE MET THE ENEMY AND THE ENEMY IS US,”
Sept 10, 1813 after the Battle of Lake Erie
Famous Naval Quote by Commodore Oliver Perry

**Growth of Physicians and Administrators 1970-2009**

- Physicians
- Administrators
- Percent growth in U.S. healthcare spending per capita

*Source: Bureau of Labor Statistics, MCHS and Himmelstein/Wynder analysis of CPS*

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**CBO JULY 2016**

Figure 3-1.

**National Spending for Health Care, 2014**

Total health care spending amounted to $2.9 trillion in calendar year 2014, about half of which was private spending. The federal government subsidizes a substantial part of that private spending, primarily through the tax exclusion for employment-based health insurance.

**Total Health Care Spending: $2.9 Trillion**

- $1.0 Trillion
- $0.5 Trillion
- $0.2 Trillion

**Public Spending: $1.4 Trillion, or 48 Percent**

<table>
<thead>
<tr>
<th>Public Spending: $1.4 Trillion, or 48 Percent</th>
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**Private Spending: $1.5 Trillion, or 52 Percent**

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<tr>
<th>Private Spending: $1.5 Trillion, or 52 Percent</th>
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</table>

Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services.

- CHP = Children’s Health Insurance Program.
- a. Refers to gross spending for Medicare, which does not account for offsetting receipts that are credited to the program. Those offsetting receipts are mostly premium payments made by beneficiaries to the government.
- b. Includes federal and state spending.
**FIGURE 2: Overview of Key Industry- and Government-Led Initiatives to Standardize and Increase Adoption of Electronic Administrative Transactions**

**INDUSTRY INITIATIVES**
- CACH Index® develops and certifies compliance with voluntary and mandated operating rules and hosts extensive education campaigns.
- CACH Index® tracks and reports national adoption and cost.
- Some health plans require or provide incentives for providers to conduct business electronically and are hosting broad provider education events.
- Practice management systems vendors and clearinghouses increasingly offer solutions to healthcare providers that support electronic business transactions.

**GOVERNMENT INITIATIVES**
- HIPAA established and mandated use of standards (mostly based on X12) for some electronic transactions.
- ACA established standards for additional electronic transactions; required development and compliance with operating rules.
- CMS implemented requirements that healthcare providers must submit claims and receive payments electronically for Medicare.
- Several state-based initiatives and regulations have been implemented to build on HIPAA regulations.

Public and private entities both provide education and awareness to key stakeholders.

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**FIGURE 3: How Much Does the Healthcare Industry Spend on Claims-Related Business Transactions?**

<table>
<thead>
<tr>
<th>MANUAL Cost per Transaction</th>
<th>VERSUS</th>
<th>ELECTRONIC Cost per Transaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2.84 CLAIM REJECTION RECEPT</td>
<td>$0.88</td>
<td></td>
</tr>
<tr>
<td>$6.39 ELIGIBILITY/BENEFIT VERIFICATION</td>
<td>$0.49</td>
<td></td>
</tr>
<tr>
<td>$3.32 PRICE AUTHORIZATION</td>
<td>$1.99</td>
<td></td>
</tr>
<tr>
<td>$5.79 CLAIM STATUS INQUIRY</td>
<td>$1.65</td>
<td></td>
</tr>
<tr>
<td>$3.46 CLAIM PAYMENT</td>
<td>$0.78</td>
<td></td>
</tr>
<tr>
<td>$6.19 CLAIM REJECTION ADVICE</td>
<td>$1.09</td>
<td></td>
</tr>
<tr>
<td>$6.99 CLAIM ATTACHMENTS</td>
<td>$1.27</td>
<td></td>
</tr>
</tbody>
</table>

Findings from 2016 CACH Index®

The Healthcare Industry COULD SAVES
$9.4 BILLION ANNUALLY With Electronic Transactions.
Automating the administrative process

Percentage of transactions conducted electronically:

- Claim Submission: 93% to 94%
- Eligibility & Benefit Verification: 71% to 76%
- Claim Status Inquiries: 57% to 63%
- Claim Payment: 61% to 62%
- COB Claims: 49% to 56%
- Remittance Advice: 51% to 55%
- Prior Authorization: 10%
- Referral Requests: 0% to 7%

Reallocation processing to the front-end will result in cost reductions and increased yield.
2015 MAP Awards Winner Statistical Data

**2015 MAP Award for High Performance in Revenue Cycle: Hospital and Health System Winners**

<table>
<thead>
<tr>
<th></th>
<th>Net Days in A/R</th>
<th>Aged A/R 90 days and greater</th>
<th>DNFB</th>
<th>DNPS</th>
<th>Bad Debt Write Off %</th>
<th>Cost to Collect</th>
<th>Cash Collection</th>
<th>POS Cash Collection</th>
<th>Charity Care Write Off</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Median</strong></td>
<td>37.45</td>
<td>19.6%</td>
<td>3.90</td>
<td>0.40</td>
<td>4.40</td>
<td>17%</td>
<td>0.255</td>
<td>98.5%</td>
<td>20.5%</td>
</tr>
<tr>
<td><strong>Percentile</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>75</td>
<td>33.90</td>
<td>13.8%</td>
<td>2.63</td>
<td>0.00</td>
<td>3.33</td>
<td>0.6%</td>
<td>0.018</td>
<td>101.4%</td>
<td>36.4%</td>
</tr>
<tr>
<td>50</td>
<td>37.45</td>
<td>19.6%</td>
<td>3.90</td>
<td>0.40</td>
<td>4.40</td>
<td>17%</td>
<td>0.255</td>
<td>98.5%</td>
<td>20.5%</td>
</tr>
<tr>
<td>25</td>
<td>42.03</td>
<td>23.4%</td>
<td>5.40</td>
<td>104</td>
<td>5.48</td>
<td>2.8%</td>
<td>0.345</td>
<td>97.0%</td>
<td>12.7%</td>
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<tr>
<td>10</td>
<td>44.05</td>
<td>28.7%</td>
<td>6.40</td>
<td>177</td>
<td>7.45</td>
<td>4.3%</td>
<td>0.615</td>
<td>96.2%</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

**2015 MAP Award for High Performance in Revenue Cycle: Physician Practice Winners**

<table>
<thead>
<tr>
<th></th>
<th>Days in A/R</th>
<th>Aged A/R 90 days and greater</th>
<th>POS</th>
<th>Cash Collection</th>
<th>Schedule Occupied</th>
<th>Denial</th>
<th>Charge Line</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean</strong></td>
<td>264</td>
<td>14.5%</td>
<td>49.5%</td>
<td>102.6%</td>
<td>84.8%</td>
<td>3.9%</td>
<td>2.7</td>
</tr>
<tr>
<td><strong>Median</strong></td>
<td>264</td>
<td>16.0%</td>
<td>50.0%</td>
<td>102.7%</td>
<td>86.7%</td>
<td>3.1%</td>
<td>2.5</td>
</tr>
</tbody>
</table>

FAST & FURIOUS REV CYCLE

**THE 400 METER PATIENT ACCESS HURDLES**

1. Validate Patient Identity
2. Screen for Charity
3. Verify Pay Authorization
4. Register Data
5. Collect Patient Payment
6. Determine Patient Bill Estimate
7. Determine Proportion to Pay
8. Check Eligibility
9. Determine Propensity to Pay
10. Verify Pay Authorization
11. Validate Screen Data

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PATIENT SERVICES + CLINICAL REVENUE INTEGRITY + A/R MANAGEMENT

PRE-SERVICE CLEARANCE
PERFORM ALL ADMINISTRATIVE FUNCTIONS PRIOR TO THE PATIENT ENCOUNTER

- Propensity-to-Pay
- Address Verification & Improvement
- SSN/ID Verification
- Red Flag Alerts
- POS Standalone & Automated Batch Processing
- Registration Quality Assurance (RQA)
- Online Patient Payments
- Automated Workflow
- Dual Eligibility Review
- Medicaid Eligibility Screening
- Presumptive Charity Care
- Coordination of Benefits
- Patient Out-of-Pocket Estimates
- Search for Missing/Incorrect Insurance

NAHAM ACCESS KEYS 3.0

<table>
<thead>
<tr>
<th>ID</th>
<th>Domain</th>
<th>Access Key (AK)</th>
<th>EQUATION</th>
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<tbody>
<tr>
<td>POS 1</td>
<td>Collections</td>
<td>POS Collections in Revenue</td>
<td></td>
</tr>
<tr>
<td>POS 2</td>
<td>Collections</td>
<td>POS Collections to Total Patient Collections</td>
<td></td>
</tr>
<tr>
<td>POS 3</td>
<td>Collections</td>
<td>POS Collection Opportunity Rate</td>
<td></td>
</tr>
<tr>
<td>POS 4</td>
<td>Collections</td>
<td>POS Collection Total� POS Collections</td>
<td></td>
</tr>
<tr>
<td>POS 5</td>
<td>Collections</td>
<td>POS Collection Accounts Rate</td>
<td></td>
</tr>
<tr>
<td>POS 6</td>
<td>Collections</td>
<td>POS Collection Estimate Rate</td>
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</tr>
<tr>
<td>POS 7</td>
<td>Collections</td>
<td>POS Collection Estimation Accuracy Rate</td>
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<td>CH 1</td>
<td>Conversions</td>
<td>CH Conversions</td>
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</tr>
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<td>PI 1</td>
<td>Pre-Experience</td>
<td>PI Experience</td>
<td></td>
</tr>
<tr>
<td>PI 2</td>
<td>Pre-Experience</td>
<td>PI Experience</td>
<td></td>
</tr>
<tr>
<td>PI 3</td>
<td>Pre-Experience</td>
<td>PI Experience</td>
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<tr>
<td>PI 4</td>
<td>Pre-Experience</td>
<td>PI Experience</td>
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</tr>
<tr>
<td>PI 5</td>
<td>Pre-Experience</td>
<td>PI Experience</td>
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</tr>
<tr>
<td>PI 6</td>
<td>Pre-Experience</td>
<td>PI Experience</td>
<td></td>
</tr>
<tr>
<td>PI 7</td>
<td>Pre-Experience</td>
<td>PI Experience</td>
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<tr>
<td>PI 8</td>
<td>Pre-Experience</td>
<td>PI Experience</td>
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NAHAM ACCESS KEYS 3.0

<table>
<thead>
<tr>
<th>ID</th>
<th>DOMAIN</th>
<th>AccessKey (%)</th>
<th>EQUATION</th>
<th>GOOD Benchmark</th>
<th>BETTER Benchmark</th>
<th>BEST Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2</td>
<td>Collections</td>
<td>POS Collections in Revenue</td>
<td></td>
<td>1.0%</td>
<td>1.5%</td>
<td>2.0%</td>
</tr>
<tr>
<td>H3</td>
<td>Collections</td>
<td>POS Collections to Total Patient Collections</td>
<td></td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>H4</td>
<td>Collections</td>
<td>POS Collection Opportunity Rate</td>
<td></td>
<td>30%</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>H5</td>
<td>Collections</td>
<td>Total POS Dollars Collected</td>
<td>Total POS Collected in Chained Adjusted Dollars</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H6</td>
<td>Collections</td>
<td>Total POS Dollars Collected</td>
<td>Total POS Collected in Chained Adjusted Dollars</td>
<td></td>
<td></td>
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<tr>
<td>H7</td>
<td>Collections</td>
<td>Total POS Dollars Collected</td>
<td>Total POS Collected in Chained Adjusted Dollars</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FUTURE STATE OF ACA

<table>
<thead>
<tr>
<th>Target Area</th>
<th>2013</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured Rate</td>
<td>41%</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>Under Insured (Deductible / Co-Pay over $2,500)</td>
<td>22%</td>
<td>49%</td>
<td>52%</td>
</tr>
<tr>
<td>Medicaid Recipient</td>
<td>10%</td>
<td>18%</td>
<td>20%</td>
</tr>
<tr>
<td>Healthcare Exchange</td>
<td>NA</td>
<td>13%</td>
<td>15%</td>
</tr>
<tr>
<td>Platinum</td>
<td>NA</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Gold</td>
<td>NA</td>
<td>15%</td>
<td>17%</td>
</tr>
<tr>
<td>Silver</td>
<td>NA</td>
<td>69%</td>
<td>70%</td>
</tr>
<tr>
<td>Bronze</td>
<td>NA</td>
<td>12%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation
PERCENTAGE OF COVERED WORKERS ENROLLED IN A PLAN WITH A GENERAL ANNUAL DEDUCTIBLE OF $1,000 OR MORE FOR SINGLE COVERAGE, BY FIRM SIZE, 2006-2015

* Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductible s for PPOs.

HOW MUCH IS TOO MUCH?

Figure 1. Insured patient cost sharing is set to soar

A provider with $1 billion net annual revenues could see a 40 percent increase in patient cost sharing by 2020.

- Median household income = $53,000
- 5% OOP expenses = $2600

Sources: Assumes National Average Payer Mix and National Average Historical Bad Debt Write-Offs (2014). Accenture analysis, America’s Health Insurance Plans (AHIP), Aon Hewitt, Assistant Secretary for Planning and Evaluation (ASPE), Centers for Medicare and Medicaid, Congressional Budget Office, Health Affairs, Instinet, Kaiser Family Foundation, Modern Healthcare, RAND, Truven Health Analytics
HOW MUCH IS TOO MUCH?

Figure 2. The rise in insured patient cost sharing will boost net bad debt by 20 percent by 2020

A provider with $18 net annual revenues could see net bad debt of $51M by 2020.

- +20% Total Bad Debt Net Impact
- +39% Insured Bad Debt
- -26% Uninsured Bad Debt Net Revenue Impact

$42M $30M $12M $51M $42M $9M

Sources: Accenture analysis, America’s Health Insurance Plans (AHIP), Ann*Heirtz, Assistant Secretary for Planning and Evaluation (ASPE), Centers for Medicare and Medicaid Services, Congressional Budget Office, Health Affairs, Insured, Kaiser Family Foundation, Modern Healthcare, MBS, Tuexa Health Analytics

PROVIDER STRATEGY: REVENUE OPTIMIZATION

THREE PRODUCT SUITES

THREE CONCEPTS

ACHIEVE FOUR OBJECTIVES

Increase Yield
Cost Containment
Incremental Net Revenue Enhancement

Payment Plans
Guarantor A/R Management
Patient Revenue Management

Patient Statements & Collections
Pre-Service Clearance
Authorization

Core Claim Mgmt / Scrubber
Denial / Contract Management
Coding / Clinical Advisory Services

Better Manage the Insurance $s
Tackle the Problem of Patient Collections
Accomplish Both by Focusing on the Front End

Patient Access
Pre-Service Clearance
SHIFTING FOCUS TO PRE-SERVICE CLEARANCE (CONTINUED)

Why it’s important…

- Roughly 45% of denials are due to patient access issues
- Only 40-60% of post-service patient responsibility is ever collected
- Expectation that this individual program/function would increase yield by approximately 3% to 4%
- Tackles consumerism and patient experience head-on. Separates the patient clinical encounter from the financial clearance process in order for the visit to the provider to be purely clinically related
- Allows for the conversion of the revenue cycle to a “clinically driven, retail model”
- Provides for the horizontal integration of functionality across the revenue cycle, which will improve efficiencies, reduce the number of errors, and streamline the back-end process while enhancing the patient experience
- Provides a mechanism to manage increased volume, due to the evolution of the market to a decentralized ambulatory or outpatient care model

REVENUE CYCLE OF THE FUTURE

Medical Informatics
- Revenue Cycle becomes the technology-driven, data repository
- Source for consumer-centered care and care coordination programs

Consumer-Focused
- Revenue cycle will move from rules-based to behavior-based processing
- Create personalized plans that emphasize quality and affordability

Value-Based Reimbursement
- Systems must support dual-track processing for reimbursements / claims
- Evolution towards “fee-for-value”

Retail Model
- Move towards a “cash and carry” model where payment is received in advance
- Opportunity for “peer-to-peer” lending

Clinical Revenue Integrity
- Focus on coding and documentation
- Basis for establishing reimbursement and risk adjustment factor score

Greater Collaboration
- Sharing across the continuum of care to improve outcomes and reduce costs
- Partner of the clinical department
Are you ready?!
1906 – from humble beginnings to an industry leading healthcare system

CoxHealth Facts

**Staff**
- 10,789 employees with 600+ staff physicians

**Volunteers**
- 1,672 volunteers are members of Cox Auxiliaries with 235,359 volunteer hours

**Beds**
- 987 licensed beds

**Services**
- 958,736 clinic visits
- 200,558 days of care
- 237,755 emergency, urgent care and trauma visits
- 34,499 surgeries
- 4,373 babies born
- 36,248 ambulance services
CoxHealth Initiatives

- Improve Front-end processes
  - Integration of eligibility tools within the patient access workflow
  - Automation improvements continue in Central Access
  - E-signatures to improve workflow
  - Palm scan for Patient ID
  - Charity care determination
  - Patient Tracking Board
  - Interest Free Bank Loan as a payment option

HIGH-LEVEL LEARNINGS

- Medicaid Eligibility challenges create billing and denial issues.
- Self Pay will be a bigger portion of the future revenue cycle challenge.
- Denial and Underpayment process can create additional EBIDA improvement.
- High-level findings give confidence that CoxHealth could significantly improve revenue cycle performance.
- Detailed Contractual Due Diligence will focus on driving additional improvement opportunities and preparing a detailed process redesign plan.
Historical POS Efforts

Hospitals have historically failed to collect co-payments, co-insurance, deductibles and prior debt at time of service

- Fear – asking for money will drive patients away, patients will be dissatisfied, “they will yell at me”
- Belief that it is against the healthcare and hospital mission
- Process breakdowns – the patient will get billed for it later
- Lack of training, support and accountability – it’s not my job
Point of Service Collections

POS Expectations

- All non-emergency/non-walk-in patients are to be pre-registered
- Financial obligations are discussed with all patients
  - At least prior to day of service for pre-registered patients
    - Ideally as close to the time after the patient is scheduled as possible
  - At minimum, prior to time of discharge for other patients
- Patients with two verified insurances will not be required to make a POS payment unless pre-determined otherwise
- The primary source of information for deductibles, co-payments and co-insurance should be the electronic insurance verification tool Availity
- If unavailable for Emergency Room outpatients, the patient's insurance card should be the next source of information used
- For self-pay Emergency Room outpatients, a $300 deposit will be requested from patients prior to discharge

POS Expectations (continued)

- For self-pay Provider Based Urgent Cares, a $200 deposit will be requested from patients prior to discharge
- For self-pay Clinic Based Urgent Cares, a $100 deposit will be requested from patients prior to discharge
- Staff is to communicate daily with their supervisor as to their individual performance related to attainment of their POS goal
  - This is an essential component to the success of the POS program
  - Barriers and trends are to be identified and addressed on a concurrent basis
- It is everyone’s responsibility to ensure that cash is collected
Efficient Pre-Service Patient Access Process

Scheduling:
• All scheduled outpatient procedure’s are to have benefits verified, medical necessity checked or pre-certification being obtained

Pre-registration:
• During pre-registration; patients out of pocket responsibility is discussed and financial arrangements are made on scheduled procedure and outstanding prior debt
• If a patient is not pre-registered and will be responsible for an out of pocket expense, registrars are discussing financial arrangements with the patient at time of registration

Financial Counselor

Financial Counselors step in to assist patients with payment arrangements when they are unable to be made at the point of service and help to seek outside payment assistance such as:
• Medicaid
• Marketplace Insurance
• Other Federal, State and Local Agencies
• Charity Care/Financial Assistance

Registrars must provide Financial Counselors with accurate demographic data and financial information, such as:
• The amount the patient owes. If unknown, Financial Counselor will assist.
• Any coverage or eligibility issues
• The patient’s financial status
• An explanation as to why the patient is being referred
Point of Service Collections

Employee Training and Re-training

- Make Sure Staff Understand the Importance of POS Collections
- To Reiterate Organizational Expectations – Patient Access Collects amounts due at POS
- Techniques That Produce Results
- Requests for payment are made professionally
- Processes are formally designed to reduce bad outcomes
- Frequent feedback is given to staff regarding progress
- Staff believes collecting POS payments is part of the hospital’s mission
- Remember – No Money, No Mission
- Accountability is assigned to all Patient Access personnel to surpass goal
Point of Service Collections and Where We Have Come

POS Totals By Year
2013: 4.5 Million
2014: 8 Million
2015: 9.2 Million
2016: 9 Million
2017 Year to Date: 7 Million

“The Fast and the Furious” Revenue Cycle – 3.0

Questions Please