“The Patient Is Now Your Third Largest Payer”

Arkansas HFMA Fall Conference
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Little Rock Marriott, Little Rock Arkansas
Doug Bilbrey – Regional Vice President, PatientMatters
Presentation Agenda

- My True Story
- Transitions 2007 – Current
- The New Reality
- The Cost of Collections
- Cash Opportunities
- Key Performance Indicators / Best Practices
- The Technology Element
- Keys To Success

My True Story

- No, I’m not going to sing the 1961 R&B Classic
- Changed Jobs at the end of 2013
- New insurance effective 2/1/14
- Wife taken to Emergency Department on Saturday 2/1/14 with stroke like symptoms
- Admitted to hospital on 2/1/14
- Medicaid Eligibility Vendor / In-House Verification processes initiated on Monday 2/3/14
My True Story (continued)

- Insurance information provided on 2/3/14
- Treatment / Services Rendered
- Discharged on 2/4/14
- Deductible paid ($2,500) in February 2014
- Balance Billed to Insurance
- Covered Charges Paid by Insurance July 2014
- Statement Received 7/19/14
- Balance Due - $3,500

So What Does This Mean?

- Patient with means to pay / commercial BCBS insurance
- Nearly six months post episode of care before final obligation known
- Imagine someone with a Bronze or Silver HIE plan having the same experience
- Imagine the experience for someone lacking the means to pay
Historical Perspective

HOW DID WE GET HERE?

Transitions 2007 - Current

- Economic downturn / decrease in elective procedures
- Higher unemployment
- Regardless of Expansion decision – Medicaid has expanded
- Employers offering higher deductible / higher co-pay plans to employees
- Majority of HIE plans selected are Bronze and Silver
HealthCare System NEW Reality

Impact on Your Patient

- **Low Crisis**
  - Early 2000s
  - High-deductible Insurance plans (e.g., HMO) introduced

- **High Crisis**
  - TODAY
  - Exchanges introduce great uncertainty for the patient
  - Patients do not understand their bills
  - Patients do not understand their financial responsibility
  - Patient Liability begins to shift

Impact on Your Hospital

- **Low Crisis**
  - Early 2000s
  - High-deductible Insurance plans (e.g., HMO) introduced

- **High Crisis**
  - TODAY
  - Exchanges introduce great uncertainty for the hospital
  - Expansion vs. non expansion
  - Shrinking margins
  - Rising bad debt
  - Third-Party reimbursement outpaced by inflation
  - HIT investments continue to rise to address EHR, ICD.10 and ...
A recent American Hospital Association report states that U.S. hospitals delivered $41.1 billion in uncompensated care in 2011, an amount that's increasing by 8% annually and estimated to double by 2016. Combining this with an increase in patient responsibility of up to 40% of the medical bill, the patient is now your 3rd largest payer behind Medicare and Medicaid.
HealthCare System NEW Reality

Bottom Line

Crisis

High

Low

Early 2000s

TODAY

10/17/2014

Patient Receivables are actually a hospital’s NEW CASH OPPORTUNITY

Medicare

Medicaid

Patient Responsibility

Private Insurance

Patient is your THIRD-LARGEST PAYOR!
Historical / Going Forward

- 55% of the patient financial responsibilities are never recovered
- 81% of “true” self-pay responsibilities are never recovered
- 3X the additional cost to collect from the patient vs. the payer
- In 2007 patient responsibility was 12% of the total revenue
- In 2014 patient responsibility projected to be 40% of the total revenue
- The Patient has become the number three payer behind Medicare and Medicaid
- Exchanges have and will generate larger patient responsibilities
- “Insured” patient doesn’t guarantee full payment
- Margins have slipped
- Bad Debt has increased
- A new skill set is required to enroll, educate, and advocate for the patient
- ICD.10 potentially will increase the patients responsibility

Financial Performance of Anonymous Arkansas Hospital

PROOF IN THE NUMBERS
Impact on the Bottom Line

Arkansas Hospital’s Net Margin through 12/31/13

Arkansas and Around The Nation

• Results of Hospitals’ Financial Performance similar to those across the nation.
• “Private Option” appears to have lessened stress on several Hospitals Bottom Line
• Many have recently closed the books on Fiscal 2014.
• How did FY 2014 compare with FY 2013?
• How will Round 2 of the ACA play out?
• What’s in store for FY 2015?
The Affordable Care Act

IMPACT

The Potential Impact of the Hospitals’ NEW Reality

Inflection Point

Cash Down

Debt Up

Patient Cash

Bad Debt

10/13 A Day The Will “fill in the blank”
Arkansas and the ACA

• 2010 Census
  – Total Population: 2,959,373

• Medicaid and the Uninsured
  – Medicaid Enrollment (Pre ACA): 720,907 (24%)
  – Uninsured: 510,000 (17%)

• 2014 Open Enrollment
  – Signups for QHP’s: 43,449
    • 19% Bronze
    • 67% Silver
    • 13% Gold
    • 0% Platinum
    • 1% Catastrophic
    • 90% qualified for financial assistance

• Health Insurance Exchange and Medicaid / CHIP
  – Ineligible Based on income or availability of employer coverage: 115,000
  – Eligible for Tax Credits: 114,000
  – Newly Eligible under ACA Expansion: 281,000

• “Private Option” / Mixed Results
  – Helped patients and providers
    • Through August 2014 more than 194,000 Arkansas residents have completed enrollment
  – Cost Overruns 15%

  “A failed Medicaid experiment is becoming a national nightmare”

  * The Washington Times – 4/30/14 *
Arkansas and the ACA

• Arkansas one of six Partnership Exchanges

Health Insurance Marketplaces
Use this interactive map to review the status of state action on state health insurance marketplaces, also called exchanges, and view key aspects of state-run marketplaces.

Legend
- States with state marketplaces (26 states and DC)
- States with marketplaces using federal marketplace (12 states)
- States with federal partnership state conducting plan management and consumer assistance (7)
- States with small business marketplaces (3 states)
- States with individual marketplaces (3 states)
- Federally facilitated marketplaces (12 states)
- Federally facilitated marketplace (21 states)

Arkansas and the ACA

• Arkansas Will Run Its Own Exchange
  – Arkansas Health Insurance Exchange
  – Enrollment Fall 2016
  – Coverage Begins 2017
  – Available for Small Business one year earlier
Turning Chaos into Opportunity

**CASH IS KING**

Cash Opportunities

- The Patient Is Now Your Third Largest Payer
- Opportunity to engage via “Patient Friendly Communication”
- Huge Cash Opportunity
- Improved Patient Satisfaction
- Holistic Approach to the Patient Receivable
### Operationalizing Patient Responsibility Best Practices

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<th>Ensuring Informed Financial Consent</th>
<th>Managing the Uninsured</th>
<th>Optimizing Payment Options</th>
<th>Enhancing Staff Effectiveness</th>
<th>Maximizing ED Collections</th>
<th>POS Analysis</th>
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<td>Uprfront Payment Discounts</td>
<td>Interactive Training</td>
<td>Coordinated Clinical - Financial ED Workflow</td>
<td>Opportunity Analysis</td>
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<tr>
<td>Collection of Prior Balances</td>
<td>Enhanced Eligibility Screening and enrollment</td>
<td>Standardized Down Payments</td>
<td>Dynamic Scripting</td>
<td>Clinical Staff Education</td>
<td>Comprehensive Performance Metrics</td>
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<td>Patient Obligation Statements</td>
<td>Targeted COBRA Support</td>
<td>Auto-Debit Payment Plans</td>
<td>POS Performance Bonuses</td>
<td>Nurse Facilitated Patient Checkout</td>
<td>Data-Driven Goal Setting</td>
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<td>Front-Loaded Payment Prompts</td>
<td>Aggressive Self-Pay Discounts</td>
<td>Loan Partnerships</td>
<td>Minimum Performance Thresholds</td>
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<td>Principled Care Deferral Protocols</td>
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### Managing the Uninsured-Plus

**Typical hospital funding sources accessed:**
- Medicaid
- Child Health Plus
- SSI/Disability
- Medicare for ESRD
- Maternal Newborn Medicaid

**Ensure Every Option is considered:**
- Medicaid
- Child Health Plus
- SSI/Disability
- Medicare for ESRD
- Maternal Newborn Medicaid
- Cobra
- Victims of Crime
- Ryan White AIDS Program
- Federal Drug Coverage Program
- State Drug Coverage Program
- National Kidney Health
- Chronically Ill and Disabled Children
- County Indigent Assistance
- 501(r) Documentation and Processing
- TANF (Temporary Assistance for Needy Families)
- LIF (Low Income Families)
- Spend down coverage
- BMA (Emergency Medical Assistance)
- Migrant Worker Assistance
- Public Housing Participant Coverage
- Healthcare for the Homeless coverage
- Caretaker Coverage (for dependent children)
Proactive Approach to the ACA Round 2

- Who are your “frequent flyers” / “friendly faces”?
- Are they likely to visit your hospital or health system again?
- Do they qualify for Medicaid or some other form of assistance?
- Do they qualify for subsidized Health Insurance Exchange coverage?
- Do they have the means to pay for their obligation (balance after insurance)?

Proactive Approach / Additional Considerations

- “Younger money is better money,” says Debby Essex, Aspen Valley’s director of admissions. / HFMA Patient Friendly eBulliten (7/23/14)
- The typical Medicare beneficiary paid an average of $4,734 out-of-pocket for their health care in 2010, up 44% from 2000, according to a new report. / The Henry J. Kaiser Family Foundation, July 21, 2014
- Section 501(r) Implications
- A New Approach is needed!
Key Performance Indicators / Best Practices

CURRENT STATE

- Most Hospitals average POS collections is .04% of Net Patient Revenue.
- Current RCM activities primarily focused on payer receivables
- Hospitals are better prepared to manage clinical experience and have varied success in managing financial risk and economics

---Typically only 10% of patient receivables are collected at or before the time of service---

![Diagram showing Patient Access Billing A/R Collections for A/R <90 days is outsourced. Later stage A/R is sold for a few cents on the dollar and written off.]

When Patients Learn About Treatment Costs

- 11% before treatment
- 7% at treatment
- 68% after treatment
- 11% never
- 2% other
## Patient Responsibility Collections

### Point of Service: Co-Pay & Deductible

**Importance:** Co-pays, coinsurances and deductibles represent a significant opportunity to collect at point of service.

**Performance Drivers:** Co-pay, coinsurance and deductible collection may be a standard part of the current registration and pre-registration processes, however lack of propensity payment knowledge and loans limits optimal solutions for patient.

### Point of Service: Remaining Patient Responsibility

**Importance:** POS collections only capture a fraction of total patient responsibility. Probability of payment collection falls once service has been provided, with 60% of patients not paying post-care.

**Current Performance:** Hospital staff typically does not attempt to collect past due balances during pre-registration or arrival.

**Performance Drivers:** Collecting remaining responsibility requires technologies that can quickly and accurately present prior balances, which registrars usually do not have. So although the registration process may have a process which emphasizes current obligation collections at the point of care, it ignores outstanding balances.

### Early-Out

**Importance:** The early-out period, days 1-120 after initial care, produce the highest collection rates and is crucial to self-pay collection success.

**Current Performance:** Many organizations utilize early-out services, but EO is not integrated into the advocacy process.

**Performance Drivers:** Staff has no insight into the likelihood of collection by account and are prioritizing receivables by total value instead, yielding lower collection rates.

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### Typical Patient Collections by Area

<table>
<thead>
<tr>
<th>Category</th>
<th>Collection Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ins. on PT Receivable</td>
<td>20%</td>
</tr>
<tr>
<td>Scheduling</td>
<td>15%</td>
</tr>
<tr>
<td>ED Collections</td>
<td>15%</td>
</tr>
<tr>
<td>OP Collections</td>
<td>15%</td>
</tr>
<tr>
<td>IP Collections</td>
<td>20%</td>
</tr>
<tr>
<td>Early Out</td>
<td>15%</td>
</tr>
</tbody>
</table>

### Key Performance Indicators / Best Practices

**FUTURE STATE**
### Industry Key Performance Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Leading Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point of Service as % of Total Cash</td>
<td>≥ 1%</td>
</tr>
<tr>
<td>Insurance Verification Secure Rate</td>
<td>≥ 98%</td>
</tr>
<tr>
<td>Pre-Registration Days Out</td>
<td>7</td>
</tr>
<tr>
<td>Scheduled Insurance Verification Days Out</td>
<td>7</td>
</tr>
<tr>
<td>Registration Accuracy</td>
<td>≥ 95%</td>
</tr>
<tr>
<td>Cash Collections as a % of Net Revenue</td>
<td>≥ 95%</td>
</tr>
<tr>
<td>Upfront PT Cash as a % of Total Cash Collected</td>
<td>≥ 2%</td>
</tr>
<tr>
<td>Overall Insurance Verification Rate of Scheduled Patients</td>
<td>≥ 95%</td>
</tr>
<tr>
<td>Bad Debt Write-off as a % of Gross Revenue</td>
<td>≤ 3%</td>
</tr>
</tbody>
</table>

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### Flip the Norm

**Increases in POS collections to 3%+ of Net Patient Revenue Requires Paradigm Shift**

- **Patient Access**: Segment patients based on expected cash value; differentiate treatment by channel & message
- **Billing**: Directly manage A/R collections performance
- **A/R**: Provide clear estimates; Obtain payment for copay, co-insurance and deductible
- **Verify identity**: Validate eligibility; provide financial counseling; assist in obtaining charity treatment
- **System and process changes**: track, report and monitor financially cleared patients has a significant impact on medical facility, allowing the facility to manage patients effectively across the entire health system. These improvements reduce patient rework, vendor and back office rework by 30% and improved copay collections by 50%.

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10/17/2014
The Technology Element

- Many hospitals and health systems have extensive technology components in place to assist with various aspects of the Revenue Cycle processes.
  - Eligibility Verification
  - Address Verification
  - Medical Necessity / ABN
  - Payment Portal
  - Registration Quality Assurance
- Most fail to achieve the expected outcomes as promised by the technology vendors

Failed Technology Approaches / Solutions

**WHY?**
Technology alone will not fix the problem

- Silo Approach
  - Not integrated (totally) to Hospital Information System
  - Not integrated with other Revenue Cycle Management applications
- Incomplete and outdated information
  - Payer contracts
  - Total Patient as a consumer view
- Effective utilization of purchased technology
- I.T. priorities
- Transparency

The Technology Element

SUGGESTED COMPONENTS
Suggested Components

- Registration Quality Assurance
- Address and Identity
- Insurance Verification
- ABN Screening
- Patient Estimates
- Propensity to Pay
- Patient Scoring
- Loan Qualification and Processing
- Patient Friendly Statements
- Patient Portal

The Technology Element

- Key To Success
  - 360 Degree Approach to the Patient Receivable
    - Emphasis on Patient Access
  - Service aspect
    - What will the vendor(s) do to ensure optimal utilization?
    - Payer Contract Services
  - Integration with Other Systems
    - HIS/PMS
    - Electronic Data Interchange
    - Clinical and other Documentation
A New Approach to a New Problem

THE GOOD NEWS

Suggestions for Success

• Round 2 of the ACA is an opportunity to educate patients and change behaviors
  — Internally / Staff, Physicians, Management
  — Externally / Patients, Employers, Payers
• Patients that understand their financial obligation in advance of services are far more likely to pay
• Use Social Media and On-Line tools to bolster market awareness and to improve payment cycles
• Point of Service Collections and an informed patient will yield improved patient satisfaction scores
Patients learn providers behavior / practices

- Number of bills
- Discounts
- Charity
- Collection Practices

Patients and eCommerce

- 87% of all electronic payments were made before the due date
- 13% of all electronic payments were received within 5 days of issuance
- **Patients who receive “e-Statements” and “pay online”**
  - 93% paid before the due date
  - 29% paid within 5 days
SIX KEYS TO SUCCESS

1. Leadership and employee education on the importance of patient liability collection. It’s often a culture change!

2. Standard scripting so that employees are well-prepared for conversations and the patient experience is reliable and accurate.

3. Consistent processes across all patient access areas for insurance verification, determination of patient financial responsibilities and POS collections.

4. Automated patient payment estimation, collection and posting at the point of service.

5. Robust and automated reporting to facilitate identification of opportunities for improvement.

6. Standard measurements and goals with publication of results at system-wide, facility, service and employee level.
Hospitals’ NEW Strategy

The Impact of The Hospitals’ NEW Strategy

![Chart showing financial impact over years with labels for Patient Cash and Bad Debt with and without plans showing trends over time.]

Closing Comments

- Develop and implement comprehensive strategy
  - HIE Coverage Options
  - Balance after Insurance
  - Uninsured care
  - Medicaid and other coverage options
- Hold your vendors accountable
  - Medicaid Eligibility
  - Technology
- Plan for Success
- Reap the Benefits
Sources

- The McKinsey Quarterly
- Healthinsurance.org
- Forbes.com
- Commonwealthfund.org
- The Kaiser Family Foundation
- Healthcare Financial Management Association
- The American Hospital Association
- The Department of Health and Human Services
- United States Census Bureau
- The Advisory Board
- PatientMatters Customer Experiences

Questions

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