Best Practices in Revenue Cycle Management

The Era of Financial Clearance and Patient Engagement

North Carolina HIMSS CHAPTER
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TransUnion Healthcare Solutions
"I'll have someone come in and prep you for the bill."
HONESTLY! WOULD UNIVERSAL COVERAGE BE TOO MUCH TO ASK FOR?

UNDERINSURED AMERICA
Today’s agenda:

**Revenue Cycle 101:**
- High Level Review
- Internal Drivers

**Best Practices:**
- Strategies
- Workflows
- HIMSS RCTIF G7

**So What?**
- Industry Trends
- Market Challenges

**Patient Experience:**
- Consumerism
- Medical Debt
- Collections Behaviors
Revenue Cycle 101
High Level Revenue Cycle

FRONT END
- Referrals / Orders
- Scheduling
- Financial Clearance
- Charity/Public Assistance
- Registration
- POS collections

MID CYCLE
- Charge capture
- Documentation/HIM/Coding
- Medical Necessity
- Transitions of care/Case Management

BACK END
- Claim creation, scrub, submission
- Insurance Collections/Cash
- Self-Pay Collections/Early out
- Payment Posting
- Denials and Appeal management
The Revenue Cycle

“FLOW CELLS”

Patient Access → ED → OP Lab → OP Imaging → OR → OP Cath → Labor & Delivery → Coding

< 3 days

Patient Business Services

Payers

OK to Pay?

Y

N

Bank
Needs:

- Revenue
- Expenses
- Income statement
- Cash flow
- Patient experience
- Employee satisfaction
Why?!
So What?

Industry trends and challenges
## Key Market Drivers Impacting Financial Clearance

<table>
<thead>
<tr>
<th>Key Driver</th>
<th>Description</th>
<th>Implications for Financial Clearance</th>
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<tbody>
<tr>
<td><strong>New Financial Assistance Regulations</strong></td>
<td>• 501r goes into effect Jan 1 ’16&lt;br&gt;• Allows presumptive eligibility&lt;br&gt;• Bars use of Extraordinary Collection Actions (EAC)</td>
<td>• Greater provider demand for 3rd party data sources &amp; methods for Financial Aid screening&lt;br&gt;• Decreased need for patient attestation/interview, but increased need for documentation/demonstration&lt;br&gt;• Increased need for batch Financial Aid screening before sending patients to bad debt or collections</td>
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<tr>
<td><strong>Higher Balance After Insurance Amounts</strong></td>
<td>• High-deductible plans increasing consumer BAI&lt;br&gt;• Provider liability shifting from uninsured to underinsured</td>
<td>• Greater provider need for Propensity to Pay information for effective Point of Service collections&lt;br&gt;• Increasing need for providers to offer multiple and increasingly complex payment options for patients</td>
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<tr>
<td><strong>Financial Clearance Moving to Pre-Service</strong></td>
<td>• Move to financial assistance screening before service&lt;br&gt;• Point of Service screening before service</td>
<td>• Greater need for Financial Aid and Propensity to Pay during scheduling &amp; registration</td>
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<td><strong>Increasing HIS Integration</strong></td>
<td>• Providers favoring integration over multiple vendors&lt;br&gt;• Providers looking to leverage existing HIS workflow</td>
<td>• Increasing interest in HIS interface options with major HIS vendors such as EPIC &amp; Cerner&lt;br&gt;• Less desire for “bolt-on” applications</td>
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<td><strong>Medical Debt Reporting Rule</strong></td>
<td>• New rule delays &amp; removes consumer medical debt from credit report</td>
<td>• Decreased reliance on credit data to provide insight into consumers’ ability to pay medical debts&lt;br&gt;• Increasing dependence on hospital encounter/ payment history &amp; other non-credit information</td>
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Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2014

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<tr>
<th>Year</th>
<th>Conventional</th>
<th>HMO</th>
<th>PPO</th>
<th>POS</th>
<th>HDHP/SO</th>
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<td>1%</td>
<td>17%</td>
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<tr>
<td>2012</td>
<td>1%</td>
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<td>56%</td>
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<td>2013</td>
<td>&lt;1%</td>
<td>14%</td>
<td>57%</td>
<td></td>
<td>9%</td>
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<tr>
<td>2014</td>
<td>&lt;1%</td>
<td>13%</td>
<td>58%</td>
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<td>8%</td>
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Deductibles more than doubled in last 10 years

Average deductible
2003 = $518
2013 = $1,273
2% vs 5% median income

Percent of workers with deductibles:
2003 = 52%
2013 = 81%
Average Household spends $13K annually out-of-pocket on health care

Projected % of U.S. dollar spent by consumer 2015

- Housing and utilities 19%
- Health Care 17% ($800B)
- Transportation services 3%
- Recreation services 4%
- Food services and accommodations 7%
- Food and beverages purchased for off-premises consumption 7%
- Furnishings and durable household equipment 3%
- Recreational goods and vehicles 3%
- Motor vehicles and parts 4%
- Other durable and nondurable goods 11%
- Clothing and footwear 3%
- Other services 9%

*Medical care includes all expenses, including premiums, prescriptions, and out-of-pocket costs
**Other includes food other than groceries, alcohol, tobacco, luxury items, nondurable goods and services, etc.

Bureau of Economic Analysis - Personal Consumption Expenditures by Major Type of Product and Expenditure
Premiums for employer and employee almost tripled in 10 years.
Deductibles – the gift that keeps on givin’...

Source: State Trends in the Cost of Employer Health Insurance Coverage, 2003–2013
THECOMMONWEALTH FUND
January 2015
Steady increase in wage outpaced by out-of-pocket health insurance costs...

In the last 10 years:

- **108%** increase in deductibles
- **72%** increase in premiums
- **23%** increase in worker wages
ACA exchange plan deductibles are creating more funding gaps for patients

- Bronze plans have a $5400 deductible
- Silver is at $3500
- Gold and Platinum are at $1400 and $400 respectively

Average Medical Deductible, in Plans with Separate Medical and Prescription Drug Deductibles

Among Federally Facilitated and Partnership Marketplaces in 2015

SOURCE: Kaiser Family Foundation analysis of Marketplace plans in the 37 states with Federally Facilitated or Partnership exchanges in 2015 (including New Mexico, Oregon, and Nevada). Data are from Healthcare.gov Health plan information for individuals and families available here: https://www.healthcare.gov/health-plan-information-2015/
Underinsured, defined....

- Out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 10 percent or more of household income; or

- Out-of-pocket costs, excluding premiums, are equal to 5 percent or more of household income if income is under 200 percent of the federal poverty level; or

- Deductible is 5 percent or more of household income.
Medical debt – contributing factors

“Cost sharing levels under many health plans now exceed the resources that most families have on hand...the Federal Reserve found that only 48 percent of Americans would be able to completely cover a hypothetical emergency expense costing $400 without selling something or borrowing money.”
Shift in Payment:

- Consumers now pay more for costs than their employer
- Consumers shoulder a greater up-front cost burden
- Providers must collect payment directly from the consumer, not the insurer

SOURCE: JPM Key trends in healthcare patient payments
Cash deceleration

Delays in health care payments are increasing:

- Increase in patient portion
- Regulatory changes
- Transition from Paper to Electronic workflows

SOURCE: JPM Key trends in healthcare patient payments
Hospitals have increased Financial risk...

- As more consumers are insured and their self-pay responsibility increases, **healthcare providers need to update their collections approach** to making sure revenue is coming in.

- Accounts receivable (A/R) from **insured** self-pay patients **increased 13 percent** in the past year.

- Total A/R over the same time period from **uninsured** self-pay patients **decreased 22 percent**, mostly as a result of high financial risk patients joining Medicaid in expansion states.

- For every **one uninsured self-pay patient payment dollar** in the first quarter this year, there were approximately **22 insured self-pay patient payment dollars**.

Provider Challenges

- Increased regulatory, security, reimbursement challenges

- In healthcare, it is ALL about the patient.....but the patient is confused:
  - What is my coverage?
  - What does this cost?
  - How much am I going to pay?
  - I can’t afford this?! – what do I do now

- Optimize 3rd party technology where possible
  - Providers LOVE innovation, but FEAR disruption
Revenue Cycle Disruption...

1. **Competing high-priority projects**
   - Maximize/sustain reimbursement through healthcare reform and disruption in the market
   - Teams juggle several major initiatives at once
   - ICD10, MU II, CDI, PRE REG/EMR

2. **Lack of skilled resources in several areas**
   - High turnover
   - Silo’d functional areas

SOURCE: Becker’s
Revenue Cycle Disruption...

3. **Narrowing margins and escalating costs**
   - Medicare, Medicaid and commercial reimbursements SMALLER (little/no incremental revenue)
   - Bend the cost curve - increase efficiencies and automate

4. **Significant market changes**
   - PPACA, 501(r), False Claims, Documentation
   - Underinsured/Uninsured

5. **Fragmented revenue cycle processes**
   - Viewed as a “cost” center
   - Disparate systems
   - Denials Management

SOURCE: Becker’s
Industry Best Practices

Approach and Innovation
Checklists/Gates:

- Eligibility
  - Insured / Self Pay
  - 270/271 EMR
  - 3rd party

- Verification
  - Benefits
  - Auth / Referral / Notification
  - Med nec

- Estimation
  - Matrix
  - Estimator
  - P2P
  - FPL

- Collection
  - Preservice
  - POS
  - Payment Plans
  - Loans/Credit

Proceed / document
Stop / escalate
Industry Challenges....

- ACA Disruption
- HDHPs - Patients are a payer too, versus just the insurance company
- Poor Patient Education and Financial Experience
- Uncompensated Care – Bad debt, Collections, Charity

Poor patient experience, uncompensated care
Matched with Best In Class Solutions

- Insurance Eligibility and Coverage Discovery
- Patient Payment Estimation
- Financial Assistance, Propensity to Pay
- Increased Cash flow and Presumptive Charity

Funding established, engaged patients, positive cash flow
A shift in approach to billing...

- *Post-service* collections to *front-end financial clearance*
- *Exception-based work queues* from *denials management*
- Determine *ability to pay* and ideally pre-fund high balance estimates (i.e. Deductibles) or obtain deposits from self-pay patients
- Engage patient in *advance of care* to have a financial discussion in addition to the clinical discussion
Providers must adapt their billing and collections strategies to prevent a potential increase in bad debt from impacting profits

- Financially clear patients early in the process
- Have documentation for the next person in line
- Upfront collections critical to capture whole or partial payments
- Patient payment discussions should occur throughout the treatment process
- Medical bill financing services, either directly or through partnerships, are an option to allow patients to pay over time
- Charity care plans will need to incorporate underinsured patients

Top 5 Strategies to Reduce Bad Debt in Healthcare

1. Early identification of patients that are high risk for bad debt
2. Request payment prior to services
3. Effective training of patient access staff
4. Provide reasonable financing options
5. Provide uninsured patients discounts

Financial Clearance Strategies

Funding mechanisms and financial clearance EARLY in the process:

- Scheduling, Pre-registration, Registration
- Insurance Verification Specialists (IVS) – Auths, Med Nec, Estimates, Charity
- Automated Insurance Estimates
- Deposit Schedules/Standard Work
- Self pay rates – Opt out of Insurance (HIPAA Hi-Tech)
- Financial Counseling (at Registration – incorporated into hospital design)
- Charity Program Enhancements - Website, Signage, Forms, Policies – FINANCIAL ASSISTANCE AND DEBT COLLECTION POLICIES
Why are pre-service estimates a good idea?

Becker’s:

- “It’s more important than ever for hospitals to maintain a steady stream of income...”

- “In an era of high-deductible plans, price estimation can be a critical pre-cursor to patient collections...”

- “As more time passes after care is delivered, a patient's propensity to pay decreases substantially...”
Why should patients be asked to pay in advance?

- You do not get what you do not ask for
- Patients are 65% more likely to pay when asked PRIOR to service (vs after)
- Bad debt and/or patient bankruptcy avoidance
- Ensure accuracy for other things (insurance, authorization, etc.)
Types of Financial Liability

- Self-Pay
- Indigent Programs
- Known Insurance Benefits
- Unknown Insurance Benefits
HIMSS
Revenue Cycle Improvement Task Force (RCITF)

- Brings clarity to an emerging dynamic in healthcare
- Recognized the importance of the patient experience
- Looked at the impact of patient financial satisfaction on a healthcare provider’s bottom line
- Patient satisfaction is playing an increasingly more important role
- Charged to improve the patient payment experience and reduce physicians’ and other providers’ bad debt.

SOURCE: HIMSS Revenue Cycle Improvement Task Force June 2014 “Improving the Healthcare Patient Payment Experience”
HIMSS G7

A thought-leader stakeholder group of healthcare providers, health plans, banks, information technology firms, government, employers and consumers, to help envision the healthcare financial network of the future

Opportunities in current state (WHATs):

- Greater integration between verification of insurance and benefit eligibility;
- Enhanced collection of more complete patient demographics;
- Improved mechanisms around capturing charges, coding, and claims submissions;
- Developing processes for collecting payments from an ever-changing patient financial means mix;
- Better denial management; reporting; and data analysis.

SOURCE: HIMSS Revenue Cycle Improvement Task Force June 2014 “Improving the Healthcare Patient Payment Experience”
A thought-leader stakeholder group of healthcare providers, health plans, banks, information technology firms, government, employers and consumers, to help envision the healthcare financial network of the future

Highlights of Recommendations (HOWs):

- Get a team together – “Create an internal task force comprised of team members from across the organization’s revenue cycle. Include any group with financial connections to the patient....”

- Check yourself (claims) – “Review the integrity of the organization’s internal process for submitting and adjudicating insurance claims”

- Take Inventory – “Review your organization’s revenue cycle tools and infrastructure...to give the organization integrated end-to-end solutions...and deliver greater patient experiences across the enterprise”

- Beg, Borrow and Steal – “Become familiar with the HFMA patient friendly billing project”

SOURCE: HIMSS Revenue Cycle Improvement Task Force June 2014 “Improving the Healthcare Patient Payment Experience”
Innovations...

- Often, providers also are calculating a propensity to pay score whether the patient is insured or not.
- High pre-service patient balances (i.e. deductibles) or self-pay patients are key areas to focus.
- Transactions like credit score, mortgage balance inquiry, address verification, and more can help:
  - Determine a patient’s propensity to pay.
  - Give insight into payment options.
  - Determine if a patient is a candidate for payment plans or charity care.
Workflow development

- Develop *POLICY* to support the *PROCEDURE* within the *SCOPE* of the project

- Determine:
  - When (Specific Steps – Shift Back to Front)
  - Who (Right Person, Right Job, Right Time)
  - Why (“Funding Mechanism”)
  - What (Elements of Payment)
  - How (Standard Work/Scripting/Key Phrases)
Financial Clearance Workflow
High-Balance Patient Account Workflow
Deployment Considerations

- What’s the problem?
  - Denials, cash, debt, cost to collect, patient satisfaction?
  - What is an indicator of performance? Can we measure that?

- Work the problem (think NASA)
  - Is the number better, worse, or same?
  - Can we fix it?

- Get a baseline, make a goal, assess gaps, make a plan, and execute

- PDCA
Deployment Considerations

- Cannot manage what you do not measure
- In God we trust, all others bring data
- Saying and doing are two different things
- On or Off / No “Dimmers”
- Do or do not, there is no try
Deployment Considerations

As an example...

- LEAN
  - Denials reduction task force on top 20 reasons a claim denied (PFMEA)
  - POS Collections on areas with highest bad debt (Kaizen)
  - Eligibility Denials on Insurance Mnemonic mismatch (Kamishibai)

- Projects
  - HCAHPS or other patient sat as it relates to billing process
    - Pre-service conversations and education about the billing cycle
    - Capturing Lost Revenue Task Force – key stakeholders
Deployment Considerations

- Educate staff to understand the importance asking patient for money
- Asking patients for money is a talent - hire for it
- Communicate clearly with patients about their financial responsibilities
- Establish expectations for patient payments, and identify patients with past due balances
Deployment Considerations

- Saying nothing creates confusion - let patients know exactly what to expect, they are more likely to plan ahead and be ready to pay.
- Integrate the process of patient payments into your daily workflow.
- Clearly communicate the payment policy at all encounters.
- Ask! Collect on patient payments such as co-pays and deductibles every time.
- Have clinicians remind patients to speak with the front desk staff about payments.

Deployment Considerations

- Have staff refer to pre-written scripts to request co-pays, deductibles, and previous balances
- Ask self-pay patients if they would like a credit card securely stored to pay future balances
- Establish electronic payment plan if a patient cannot pay immediately

Patient Experience

What is happening through the lens of your “consumer”
The Patient Experience...

CLINICAL PLAN

FINANCIAL PLAN
Medical debt and uncompensated care... it’s a real problem

- A recent report issued by the Consumer Financial Protection Bureau (CFPB) finds that medical debts account for a majority (52%) of debt collections actions that appear on consumer credit reports.
- An earlier Kaiser Family Foundation report found that 1 in 3 Americans struggle to pay medical bills, and that 70% who do so are insured.
- Unpaid medical bills are the highest cause of bankruptcy filings, above both credit card and mortgage debt.
- Once in debt, people may delay or forego other needed care to avoid incurring further unaffordable medical bills.
McKinsey Quarterly Survey:

• 52% of consumers would pay from $200 to $500 or more...if an estimate was provided at the point of care
• 74% of insured consumers indicated that they are both able and willing to pay their out-of-pocket medical expenses up to $1,000 per year.. (90% up to $500/yr.)

SOURCE: JPM Key trends in healthcare patient payments
If Patients Are WILLING To Pay, Why Is It NOT Happening?! 

According to patients...

- Lack of options for payment plans
- Poor timing of bills
- Difficulties coping with confusing statements or policies

SOURCE: JPM Key trends in healthcare patient payments
Patient Friendly Billing

After conducting extensive research and focus groups among patients and healthcare providers, the consensus was clear: Patient billing is a significant problem for patients and providers. Consumers want a healthcare financial communications process that is clear, concise, correct, and patient-friendly.

- **Clear**: All financial communications should be easy to understand and written in clear language. Patients should be able to quickly determine what they need to do with the communication.
- **Concise**: The bills should contain just the right amount of detail necessary to communicate the message.
- **Correct**: The bills or statements should not include estimates of liabilities, incomplete information, or errors.
- **Patient Friendly**: The needs of patients and family members should be paramount when designing administrative processes and communication.

[www.hfma.org/patientfriendlybilling](http://www.hfma.org/patientfriendlybilling)
Guiding Principles

- Needs of patients come first
- Access to services are not denied based on the consumer’s ability to pay
- Consumers who have the ability to pay for health services do pay
- Healthcare providers receive reliable, fair, and timely payment for services provided
- Information should be coordinated when obtaining, and easily understood when communicating
- High-deductible health plan cost sharing processes do not add to the complexity and cost of healthcare administration

www.hfma.org/patientfriendlybilling
Organizational Strategies

- For patients with the ability to pay, explain the amounts that are due in advance, and collect the estimated financial obligation in advance or at the time of nonemergency services.
- In addition to establishing payment terms early in the patient encounter, also offer payment arrangements or financial assistance if you become aware that the patient needs assistance.
- Approaches to payment arrangements may include requiring a minimum monthly payment and a maximum length of time to pay, establishing payroll deduction programs, and referring patients to external financing sources, among other arrangements.
- Tailor pre-service collection and financial counseling practices to the patient’s specific type of benefit plan. For example, design processes to accept automatic payments from health savings account or health reimbursement arrangement debit cards.
- Develop specific and fair discount policies for uninsured patients.

www.hfma.org/patientfriendlybilling
Patient Friendly Billing Project

Best Practices for “Financial Clearance”

- Charge master/pricing strategy clearly defined
- Insurance eligibility checking
- Verification of patient insurance benefit levels
- Precertification
- Medical necessity checking
- Referral authorizations
- Identification and communication of each patient’s out-of-pocket obligation (copayment and deductibles)
- Financial counseling, including payment plans and alternate payment arrangements
- Special handling” accounts (package pricing)

www.hfma.org/patientfriendlybilling
In summary...

- Critically analyze market trends and evaluate best practices
- Adopt what would work well in your organization
- Identify the components and scale the project to the resources available
- Invest in technology to move the numbers
- Train, retrain, and adapt the workflows
- Educate staff, customers, and community
“With effective programs in place, and the technological tools and training to deliver top-notch customer service, Healthcare Organizations in the vanguard of POS collection are finding patients to be not resentful but grateful”

- Healthcare Financial Management, Sept, 2007 by Margie Souza, Brent McCarty
Questions??
THANK YOU
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