Transforming Point of Service Collections (PR3)

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Presenters

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A new paradigm in healthcare

• Transparency and consumerism are creating shockwaves of change challenging the way healthcare operates.

• Transparency and the shift of financial burden from payers to patients are cornerstones driving healthcare reform.

• Processes will change. Tools will emerge.

• Don’t let the tail wag the dog.

Transparency vs. Consumerism

• Transparency – Making meaningful information available to patients about cost and quality

• Consumerism – A patient’s response to transparent information.
The psychology of buying

• Proving a patient with an estimate is about EDUCATING them about their financial responsibility.

• Patient’s need to understand why they owe the provider.

• Definition of a contract: offer and acceptance.

• Transform the post-service adversarial relationship to a pre-service advocacy for the patient.

Consumerism
Ground Rules

- Better information must flow from the physician to the facility at the time of scheduling

- Better information is required from the payers

- Registration is now patient access and POS staff are required to collect

- Patient estimations requires change

Contracts vs Claims

Contracts
- Contracts define reimbursement
- Historical charge data only needed for POC
- Can determine impact of implants, drugs, multiple procedures
- Can use last year’s data
- Most credible estimate
- Defendable

Claims
- Historical claim information
- Yesterday’s claim is tomorrow’s estimate
- Can’t determine impact of implants, drugs, multiple procedures
- Can’t use last year’s data
- LOTS of data
- Can’t defend
HFMA Pulse Nov 2009

• Overview of Findings
  – 97% of hospitals surveyed have experienced an increase in self-pay accounts receivable compared with prior fiscal year
  – Small hospitals were most likely to experience a self-pay increase of greater than 10%
  – Receivables are growing faster than patient revenue at almost one-third of respondent hospitals
  – Emergency departments and unscheduled outpatient services are experiencing the most self-pay growth
  – Difficulty estimating the cost of charges is a significant barrier to point-of-service collection
Self-Pay Trends: Accounts Receivable

97% of respondents experienced an increase in self-pay accounts receivable compared with the prior fiscal year. Of these hospitals:

- More than one-third have experienced an overall increase of 10% or greater
- 39% have experienced a growth in self-pay balance after insurance of 10% or greater
- One in five have had a 10% or greater increase in bad debt write-offs

Self-Pay Trends: Hospital Size

Small hospitals (1-100 beds) were most likely to experience a self-pay increase of greater than 10%. Of these small hospitals:

- 45% experienced a greater than 10% self-pay increase, compared with 36% overall.
- 64% saw self-pay balance after insurance rise by more than 10%, compared with 39% overall.
Self-Pay Trends: Receivables Growth as Compared with Patient Revenue

Receivables are growing faster than patient revenue at almost one-third of hospitals. Only 10% indicate that patient revenue is outpacing receivables.

What Hospitals Are Doing?

- 72% of respondents report that they are devoting moderate or substantial efforts toward point-of-service collections in their facilities
  - Only 50% of hospitals that are shifting resources toward point-of-service collections are seeing decreases in their cost-to-collect performance indicator

- Respondents are indicating that difficulty in estimating the cost of services to be received remains the most significant barrier to more extensive point-of-service collections
Revenue Cycle Response to Market Trends

Respondents have increased accessibility of financial counselors and have increased collection activity.

Response to Self-Pay Market Trends

- Increased collection efforts: 87%
- Increased accessibility of financial counselors to assist patients: 79%
- Increased segmentation of self-pay balances: 41%
- Implementing/considering alternate finance options for patients: 41%
- Expanding patient billing customer service hours: 13%

Source: HFMA’s Healthcare Financial Pulse (www.hfma.org/pulse)

We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities.

Sponsors

Centura Health

- Largest Colorado health care provider
  - $1.8B in revenues
  - 13,000 employees
  - Nearly 6,000 affiliated MD’s

- Services
  - 13 hospitals
  - Clinics with ~200 providers
  - 7 senior living communities
  - Home care
  - Hospice
Where is Centura Health?

• St. Anthony Granby Medical Center
• St. Anthony 7 Mile Medical Clinic
• Breckenridge Health Services
• St. Anthony Summit Medical Center
• St. Anthony Copper Mountain Clinic
• St. Anthony Keystone Medical Clinic
• Breckenridge Medical Clinic
• St. Thomas More Hospital
• Progressive Care Center
• Centura Health at Home
• St. Mary-Care of Medical Center
• Villa Pueblo Senior Living Community
• Centura Health at Home
• Durango
  • Mercy Home Health
  • Hospice of Mercy

Point-of-Service Collections: Opportunity

• Centura lacked a robust tool for price estimates along with standardized process

• Current performance: Point of service collections were < $500K

• Industry best practices indicated that Centura Health had the opportunity to improve collections at least $1,000,000 per month
Point-of-Service Collections: Tool-Kit

**Process:** Understanding the Why, How, What, When

**Technology:** Implementing technology that enhances your process

**Accountability:** Instilling accountability at all levels

**Results:** Utilizing proper tools, implementing P&Ps, and standardizing processes to achieve successful collections

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Point-of-Service Collections: Tactics

- **Establish Accountability & Goals**
  - Clearly defined goals (collections within 5 days of discharge)
  - Established goals by patient type; described goals in the way frontline staff could relate
  - CFO’s established expectations at facility level
  - Developed staff incentive program

- **Provided Staff Training**
  - Developed and provided staff training, in partnership with a consultant, at all acute sites
  - Created on-line training

- **Improved Processes**
  - Determine patient portions for scheduled services
  - Communicate with patients about their portion; educate them about their financial responsibility
  - Collect at or before the time of service

- **Implemented Tools**
  - Selected a business partner that provides defensible estimates
  - Price estimator tool implemented
Best practices suggest a goal of 1-3% of total Net Patient Revenue (NPR). Centura’s goals vary by hospital; overall goals are:
- 1.0% in FY10 (individual hospitals range from 0.8% to 1.5% of NPR)
- 1.3% in FY11 (individual hospitals range from 1.0% to 2.2% of NPR)

The methodology to set the hospital goals is based on hospital volumes and patient mix; expected POS collections by patient type for FY11 are:
- Outpatients: $50
- Same Day Surgery Patients: $250
- Emergency Room Patients: $25
- Inpatients: $200

Several categories of patients are excluded:
- Patient Types: Observation patients, recurring patients, newborns
- Financial Classes: Auto, Charity, Medicaid, Medicare, Workers Comp
- Locations: Mammography, Lab, Flight for Life

Daily and monthly reporting provides staff and leadership regular feedback on performance and areas for improvement

Staff incentive plan kicks in when collection exceed goals
Point-of-Service Collections: Access Policy

**STATEMENT OF POLICY:** It is the policy of Centura Health to centralize and maintain user access to the FHS system.

**POLICY:** Patient Access Management will notify the FHS Primary Administrator to request access for new user’s as well as requests to delete user’s that will no longer require access.

**PROCEDURE:**
- When a request is being made to add a new user. The requester must e-mail the Primary Administrator and include the user’s full name, phone number, email address, facility, and a signed service agreement. The new user must access the FHSCorp ClearQuote e-learning course located in LEARN on the virtual workplace and complete the course and pass with a score of 80% or greater. Once these results are received the user will be set up and will receive a confirmation e-mail from the Primary Administrator.
- When a request is being made to delete an existing user. The requester must e-mail the Primary Administrator and include the users name, facility and deactivation date.
- Users may request a password reset within the FHS software by clicking on “I’ve forgotten my password” link. The user will be prompted to enter their user ID. A system generated password will be sent to email address associated with the user ID. Users may call the support number for assistance.
- Appropriate use of this system will be monitored on an ongoing basis. Users that inappropriately gather or disclose information about themselves, associates, or others except as necessary for official duties will be subjected to disciplinary action up to and including termination.

Point-of-Service Collections: Scripting

At registration, use the following script to ask the patient or appropriate family member how they will pay for their portion due:
- “Mr./Ms. (Insert Patient Name), per your insurance carrier/plan you have an estimated amount due of $(Insert Dollar Amount). How would you like to pay for that today, cash, check, or credit card?”
- “This is an estimate of your liability based on the information available from your insurance company. Additional amounts due may be billed to you after your insurance company receives and processes the claim.”

**Patient:**
- “I don’t want to pay today. Just bill me.”
Point-of-Service Collections: Scripting

Patient Access Representative:
• “I understand Mr./Ms. (Insert Patient Name); however, it is required by your insurance plan that you pay for a portion of your services. I will be happy to process this payment for you now. How would you like to pay for this service today?”

Patient:
• “I thought my insurance paid for everything / I have already met my deductible.”

Patient Access Representative:
• “The amount I am requesting today is the amount that your insurance company has indicated is the patient portion (co-insurance or co-payment amount). You may call your insurance company to clear up any concerns you may have. How would you like to pay for this service today?”

Point-of-Service Collections: Scripting

Patient (prior to and on date of service):
• “You have never asked me for payment before, you have always billed me.”
• Prior to Date of Service – “I apologize if there were previous inconsistencies in our processes, but we are now required to request payment on or before the time of service when the insurance carrier indicates there is a patient liability. We will be happy to process the appropriate payment for you upon arrival on your day of service.”
• On Date of Service – “I apologize if there were previous inconsistencies in our processes, but we are now required to request payment at the time of service when the insurance carrier indicates there is a patient liability. How would you like to pay for this service today?”
**Reference Material - Incentive Plan**

- **PROCEDURE:** The following guidelines are to be applied when applying the Patient Access At-Risk Plan:
  - Associates in positions where there is a direct ability or responsibility to collect POS collection and who collect $0 for the month will not be eligible for payment for that respective month.
  - Associates who do not participate in the overall process of POS collections are not eligible to participate in this plan.
  - Payments will be paid to the eligible associates based on Facility attainment of targets as previously established.
  - Plan pays on POS collections only. POS is defined as collections posted 0 through 5 days after discharge or registration.
  - Daily tracking of associate collections and metrics will be the responsibility of the Patient Access department.
  - Payments will be paid out monthly for each calendar month, on the pay period following the end of the previous month.
  - Payments will be based off of productive hours worked in the previous month and paid as a % of those hours times the midpoint of the grade for which the associate is based.
  - Facilities can choose to opt in or opt out of the at-risk program

- **Payment Eligible and Parameters:**
  - The associate forfeits the total amount of payment award if they voluntarily or involuntarily leave Centura for any reason prior to the pay out for that respective month.
  - There is a maximum per/person payout of $12,500 annually.
  - Minimum payout will be $25.
  - Payments will be paid and taxed according to IRS regulations.
  - Evaluation of the goals and targets will be done at least twice per fiscal year and may change/delete or modify eligibilities as necessary. If changes are made, advanced communication will be completed prior to implementation.

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<tr>
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**Background on Riverside Health System**

- 5-hospital system located in southeastern Virginia
- $1 billion in gross patient acute care revenues, 710 licensed beds
- Flagship hospital has over 28,000 discharges and 53,000 ED visits annually
- Central business office managing approximately 68,000 open patient accounts
Why implement ClearQuote?

![Insured Nonurgent OP Bad Debt](chart.png)

**Implementation Roll Out**

- **Phase 1**
  - Print price quotes for scheduled patients
- **Phase 2**
  - Mail price quotes to scheduled patients
- **Phase 3**
  - Use Transunion Credit Scoring to determine
    - Financial ability to pay and/or charity determination
    - Credit worthiness
  - Require payment for those OP that aren’t credit worthy
- **Phase 4**
  - Limit payment plans based on lack of other credit options
- **Phase 5**
  - Expand to 400+ physicians
Automate Charity Application

- Based on the FLP%, charity will be awarded at time of service.
  - Below 200% FLP
- Currently done at day 60
- Reduce manpower to process manual applications.
- Requires a change in charity policy to accept third party verification replacing manual, paper applications.

Riverside’s Results
QUESTIONS?

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