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PATIENT FINANCIAL DECISIONS

Get the Right Data • At the Right Time • To the Right People

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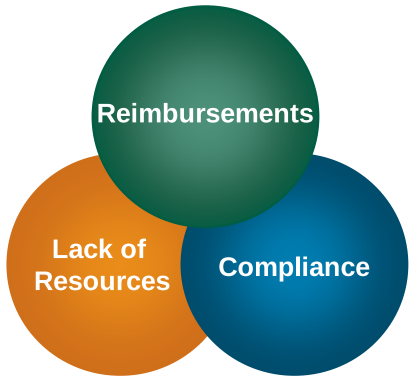
Agenda

- Healthcare Industry Challenges
  - Pre-service
  - Post-service
- External Data Sources
  - What kind of data?
  - Why use it?
- Choosing the Right Delivery Channels
  - One size does not fit all

Let's Agree…

There are BIG issues confronting hospitals and the healthcare industry today



Reimbursements
- –Increased unemployment – more self-pay / uninsured
- –Rising patient balances – underinsured, high deductible plans
- –Benefit plan complexity
- –Fraud

Lack of Resources
- –FTEs – hiring freezes, cut backs
- –IT / IS constraints
- –Budget

Compliance
- –Internal policies
- –Federal – Red Flags, EMTALA

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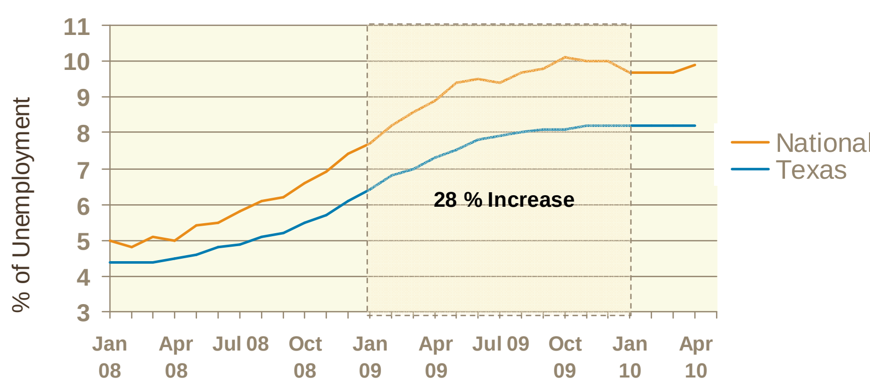
Texas Unemployment

The economy has an immediate impact on patients' ability to pay – experienced a 28% increase from Jan 2009 – Jan 2010



Source: U.S. Department of Labor, seasonably adjusted rates, April 2010 data

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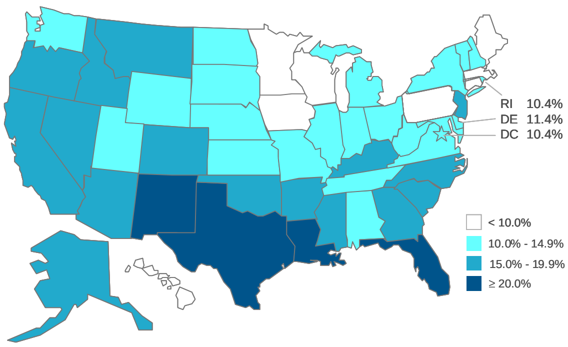
Texas Uninsured Rate – 24.9%

Average percent uninsured by state, 2006 – 2008

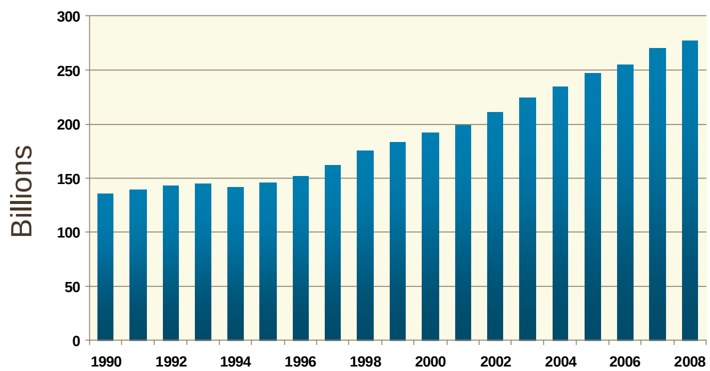


More than 5.8 million Texans – including 1.5 million children – lack health insurance, 1.5 to 2 times the national average*

Source: US Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2008. Data released August 2009. Link: http://www.census.gov/hhes/www/hlthins/hlthin08/hlthtables08.html.
*Texas Medical association. Link: http://www.texmed.org/Template.aspx?id=5517

Consumer Out-of-Pocket Payment Growth

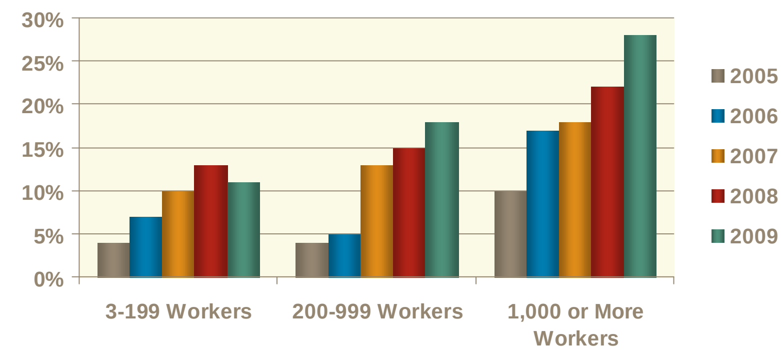
Consumer out-of-pocket payments for national health expenditures, 1990 – 2008(1)



Source: Centers for Medicare & Medicaid Services, Office of the Actuary. Data released January 5,2010. AHA Chartbook.
(1) CMS completed a benchmark revision in 2006, introducing changes in methods, definitions and source data that are applied to the entire time series (back to 1960). For more information on this revision, see http://www.cms.hhs.gov/NationalHealthExpendData/downloads/benchmark.pdf

More Firms are Offering High Deductible Plans

Percentage of firms offering health benefits that offer a high deductible health plan with a savings option (HDHP/SO), by firm size, 2005 – 2009



Source: Kaiser Family Foundation/Health Research Educational Trust, "Employer Health Benefits: 2009 Annual Survey

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Pre-Service Challenges

Process	Registration	Insurance Eligibility	Patient Payment Estimation	POS Collections	Financial Counseling
Challenges	• Verify patient identity and self-reported information • Reduce errors • Avoid claims denials • Increase compliance	• Verify insurance eligibility and benefits • Avoid manual verification calls • Reduce claims denials • Increase POS collections	• Provide an accurate estimate of what the patient owes • Increase POS collections • Decrease A/R days • Improve patient satisfaction	• Make objective ability-to-pay decisions • Increase POS collections • Decrease A/R days • Standardize charity care determination process	• Match patients to the appropriate funding sources • Accurately identify charity care • Standardize charity care determination process

Increase Workflow Efficiencies

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Critical Business Issues: Pre-Service

Process	Critical Business Issues
Scheduling, Pre-Registration, Registration	**Positive and Accurate Identification of Patients – WHY?** *Every process is negatively affected if the patient ID is not verified* • Poor hit ratios on insurance verification • Decreased collections • Increased costs – returned mail, medical follow-up • Reduced reimbursements / increased insurance denials • Compliance gaps – Red Flag Rules • Increased patient safety issues
Insurance Eligibility Verification	**Accurate and Reliable Insurance Eligibility Verification – WHY?** *Patient benefit information drives the largest reimbursement area* • Accurate benefit information is essential for third party billing • Accurate benefit information reduces claims denials • Accurate benefit information is necessary to estimate patient out-of-pocket / responsibility

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Critical Business Issues: Pre-Service

Process	Critical Business Issues
Patient Payment Estimation	**Patient Friendly Billing and Transparency – WHY?** *With the growing number of uninsured and underinsured, out-of-pocket responsibility is increasing, resulting in the need for patient friendly billing and transparency* • Self-pay balances continue to rise – need to decrease the cost of collection • Traditional collection rates are stagnant or decreasing • Macro economic factors (unemployment, etc.) are increasing the need for more effective POS collections • Increasing consumer directed healthcare will drive patient healthcare choices

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Critical Business Issues: Pre-Service

Process	Critical Business Issues
Point-of-Service Collections	**Financial Clearance – WHY?** *Determining the patient's ability-to-pay and if they qualify for financial assistance is a key driver for increased collections at the POS* • Self-pay balances continue to rise • Traditional collection rates are stagnant or decreasing • Macro economic factors (unemployment, etc.) are increasing the need for more effective POS collections • Difficulty determining which patients have the ability, capacity and propensity to pay
Financial Counseling	**Charity and Financial Aid Screening – WHY?** *Matching uninsured or underinsured patients to the appropriate funding sources is a critical revenue source* • Numerous programs and requirements • Tedious manual processes to qualify and enroll patients into appropriate programs • Lack of patient involvement to provide supporting financial information

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Post-Service Challenges

Process	Third Party Follow Up	Self-Pay Collections	Medicaid Re-verification	Charity Determination
Challenges	• Get accurate and up-to-date claim status information • Reduce claims denials • Decrease A/R days	• Focus post-service collections efforts on the accounts that will provide the greatest return • Allocate billing resources more efficiently • Decrease cost-to-collect • Reduce A/R days	• Efficiently re-check self-pay accounts on the back-end • Increase reimbursements • Decrease A/R days • Decrease bad debt	• Discern true charity care from bad debt • Address IRS 990 Schedule H • Reduce bad debt • Lower cost-to-collect

Increase Workflow Efficiencies

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Critical Business Issues: Post-Service

Process	Critical Business Issues
Third Party Follow Up	**Automated Claims Status Inquiry – WHY?** *To get paid for services* • Reduce expenses for third party follow up • Reduce resource requirements for follow up • Increase reimbursements
Self-Pay Collections	**Collection Prioritization – WHY?** *Reduce cost of collections and focus on the accounts that will provide the greatest return* • Decrease cost-to-collect – reduce mail and telephone expenses • Increase staff productivity – allocate billing resources to focus on the accounts that can and will pay (80/20 rule) • Decrease external third party collection contingency rates

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Critical Business Issues: Post-Service

Process	Critical Business Issues
Medicaid Re-Verification	**Identify Self-Pay Accounts that were Enrolled in Medicaid at the Date of Service – WHY?** *Recover reimbursements from self-pay accounts that were previously thought to be uninsured* • Difficulty identifying all Medicaid coverage at registration • Lost reimbursements from accounts that will most likely roll to bad debt • Identify opportunities for future billing based upon current coverage
Charity Determination	**Discern true charity care from bad debt – WHY?** *Address IRS 990 Schedule H reporting requirements* • Accurately report and track charitable giving • Lack of patient involvement to provide supporting financial information • Inability to identify patients truly in need – resulting in wasted collection efforts

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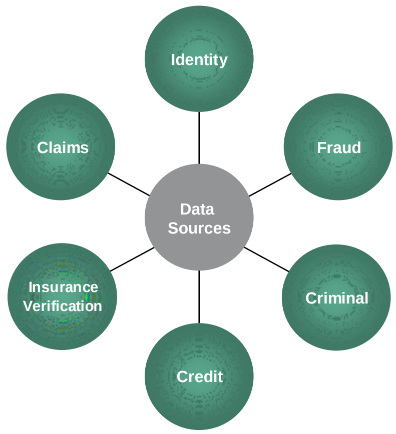
External Data Sources

Incorporating external data and analytics at key points in the revenue cycle drives better financial outcomes



- Prior to admission screening
- Time of admission screening
- Financial counseling
- Back-end billing and collections
- Reporting

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Why use external financial and identity data in a healthcare setting?

Helps treat patients consistently and within your policies

- Improves ability to make objective ability-to-pay decisions up front and negotiate appropriate payment amounts and payment plans for those patients who can pay
- Provides patients who cannot pay with appropriate funding options
- Reduces errors during registration process – provides clean data for downstream processing
- Increases point-of-service and back-end collections

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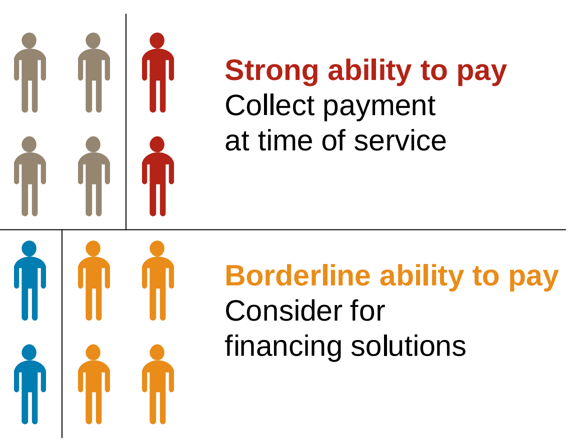
Does your patient population look like this at the time of registration?

- Can they pay at the time of service?
- Will I have to collect on the back-end?
- How will they impact my A/R days?
- Are they eligible for financial assistance?
- Are they who they say they are?
- Are they giving me an accurate name, address, phone number, SSN and date of birth?

External data and analytics helps reveal a patient's true financial situation

FPL < 100%
Potential charity care or Medicaid

Strong ability to pay
Collect payment at time of service



Identity issues
Potential fraud

Borderline ability to pay
Consider for financing solutions

Choosing the Right Delivery Channel

One size does NOT fit all – a large, single platform is not always the best solution for many reasons:

- Budgets are tight
- Limited IT resources
- Multiple users have varying needs
  - Registrars
  - Financial Counselors
  - Collectors

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Mini Applications (Mini-Apps)

PURPOSE → "Light-weight" software applications that deliver the right data, to the right person (registrar, collector, etc.), at the right time to support decision making during a given process

FEATURES →

- Focused functionality
- Easy to deploy
- Low cost to support
- Compatible with HIT systems
- Post back capabilities to HIT systems
- "In process" data delivery

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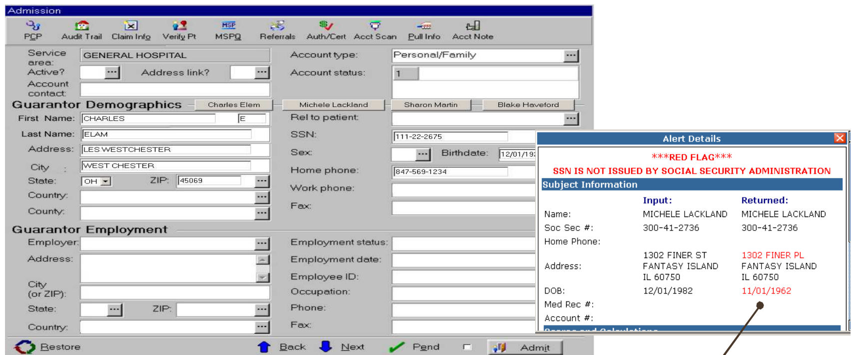
Identity and Address Verification



- Patient identity information is sent to vendor via a standard HL7 feed from your registration system
- Patient registration information is compared against multiple data sets
- Input and external data is returned for side-by-side comparison
- User is alerted of any discrepancies, alerts or Red Flags via a pop-up message that displays in front of the registration screen

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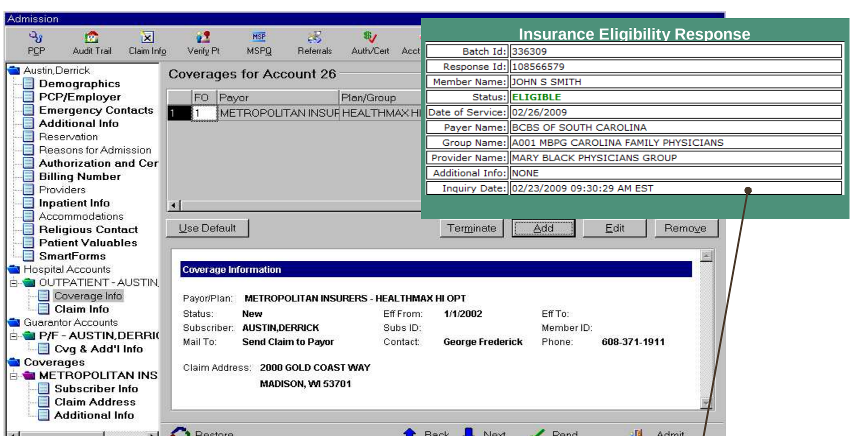
Insurance Eligibility Verification



- Coverage and benefit information is integrated into your patient registration system via a standard EDI process (270/271)

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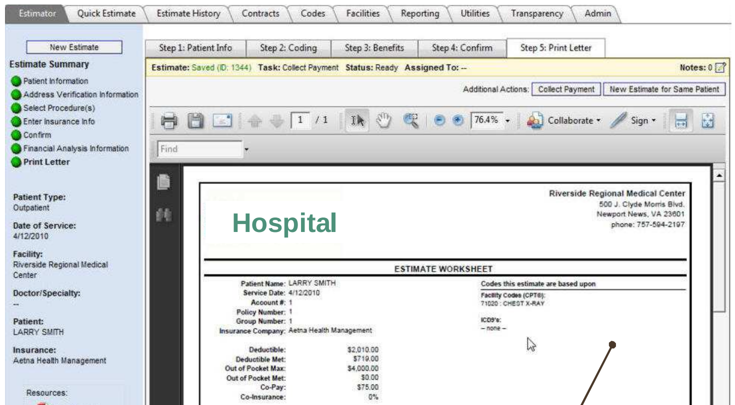
Patient Payment Estimation



- App is loaded with payment history information and manage care contract terms
- Patient identity information is sent to app via HL7 feed from your registration system
- User enters service information; app runs an insurance verification transaction
- Automatically generates a patient financial responsibility estimation letter

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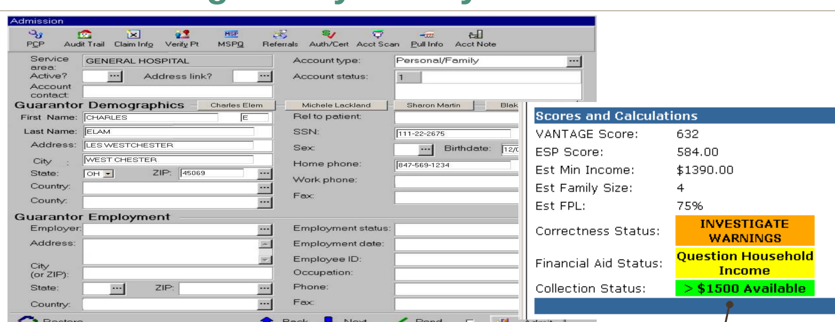
Determining Ability-to-Pay Decisions



- Patient identity information is sent to vendor via a standard HL7 feed from your registration system
- Patient registration information is compared against multiple data sets and uses the patient's credit report to calculated financial estimates – including probability of financial aid and likelihood of collection
- Easily set tailored thresholds, like FPL% cutoffs, that correspond to customizable decision messages, such as "Qualified for Medicaid"
- Pop-up messages display in front of user's registration screen with financial estimates and color-coded decision messages

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Thank You

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