Eligibility and Point of Service Collection Practices that Work

Douglas Turek
Senior VP of Regulatory and Governmental Affairs
MedData (formerly Cardon Outreach and Alegis)

TAHFA Roadshow
Dallas, Texas
July 28, 2017
• Provide for Eligibility and Point of Service Collections:
  – The Need for the Efforts;
  – The Goals of each Effort;
  – The Practices that Work to Achieve the Efforts; and
  – The Potential Rewards for a Successful Effort
ELIGIBILITY
WHY IS ELIGIBILITY IMPORTANT?
Eligibility is Important in Texas because:

- Ages 19-64
  - National Uninsured Rate = 12.5%
  - Texas Uninsured Rate = 21.6%
- Ages 0-18
  - National Uninsured Rate = 5.2%
  - Texas Uninsured rate = 8.6%
- Highest in the Country for Both Age Groups
- From Texas Medical Association
Figure 5
Uninsured Rates Among the Nonelderly by State, 2015

SOURCE: Kaiser Family Foundation analysis of the 2016 ASEC Supplement to the CPS.
Figure 4

Characteristics of the Nonelderly Uninsured, 2015

Total = 28.5 Million Uninsured

NOTES: The U.S. Census Bureau’s poverty threshold for a family with two adults and one child was $19,078 in 2015. Data may not total 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of the 2016 ASEC Supplement to the CPS.
Primary Reason for Being Uninsured Among Uninsured Nonelderly Adults, 2015

Share who say the primary reason they are uninsured is because they:

- Tried to get coverage but too expensive: 46%
- Didn't know about requirement to have health insurance: 7%
- Would rather pay the fine: 9%
- Tried to get coverage but was unable: 11%
- Didn't think the requirement applied to him/her: 13%
- Other: 14%

NOTE: “Other” includes respondents who said the primary reason was “some other reason”, respondents in the process of signing up for insurance, and respondents who didn’t know/refused to respond.

SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted December 1-7, 2015)
Figure 7

Problems Paying Medical Bills by Insurance Status, 2015

Among insured and uninsured non-elderly adults, over the last 12 months:

- Problems paying or unable to pay medical bills: 53% uninsured, 20% insured
- Problem with medical bills led to using up all or most savings: 27% uninsured, 13% insured
- Problem with medical bills led to difficulty paying for basic necessities: 21% uninsured, 7% insured
- Problem with medical bills led to borrowing money: 22% uninsured, 8% insured
- Problem with medical bills led to being contacted by collection: 27% uninsured, 13% insured

NOTE: Includes adults ages 18-64. All differences between uninsured and insured groups are statistically significant (p<0.05).
SOURCE: Kaiser Family Foundation/New York Times Medical Bills Survey (conducted August 28-September 28, 2015.)
WHAT ARE THE GOALS OF AN ELIGIBILITY PROGRAM?
Program Goals

- **Evaluate** Uninsured Patients to Determine if Potentially Eligible for Coverage that will Reimburse the Hospital for Treatment
- **Engage** Potentially Eligible Patients in the Application Process
- **Achieve** all Eligible Coverage Opportunities
- **Obtain Reimbursement** from Eligible Coverage
PRACTICES THAT WORK
Practice #1 – Be Comprehensive

• Ensure that ALL true Uninsured Patients are in the Program
  – All Classes of Patients:
    • Initially Registered as Uninsured
    • Initially Registered with Coverage Incorrectly
  – All Points of Entry:
    • Inpatient
    • Emergency Department
    • Outpatient Clinics
Practice #2 - Engage the Patient

• Achieving Eligibility is Patient Dependent
• All Contacts must build Rapport with the Patient
  – Relationship Building
  – Education
  – Clear Communication of What is Needed
• Go the Patient if Necessary (Field Visits)
• Eligible Patients Often Do Not Complete the Process Even through Eligible
  – Texas Experience = 5% to 18% Non-Compliant or Non-Cooperative
Practice #3 – Be an Advocate

• Make the Eligibility Program an Advocacy Program
  – Presentation to the Patient
  – Treatment of the Patient
  – Follow-through with Promises
  – Explain and Educate on Benefits

• Advocacy turns this Program from a Negative into a Positive Patient Experience
Practice #4 – Utilize all Programs

• Ensure that all Programs are Explored
  – Medicaid
  – Social Security Disability
  – County
  – Crime Victims
  – Other Local, State and Federal Programs

• All Eligibility is Better than the 1-3% True Uninsured Collection Rate
Practice #5 – Take Ownership

• Take Ownership of the Effort
  – Own Every Action
    • Complete Applications
    • Obtain and Follow-up on Documentation
    • Communicate and Worth With Governmental Agencies
    • Remind Patients of Appointments
    • Maintain Constant Communication
  – Patient only Needs One Excuse to Stop
• Stop Leakage of Value
  – Ensure Accounts are Billed Timely
    • 95 Day Medicaid Billing Deadline
    • 365 Day Dummy Billing
    • Texas Experience = 4% to 16% of Reimbursement Lost to Billing Errors
  – Ensure Erroneous Denials are Appealed
    • Texas Experience = 3% to 11% of Reimbursement Lost to Unchallenged Denials
Practice #7a – Utilize Technology

- Utilize Data Collection Strategies
  - Either:
    - Use Digital Media at Screening, or
    - Track Data in Systems Post-Screening
  - Utilize Electronically Stored Data to Generate Applications and Forms
  - Utilize Electronically Stored Data to Identify Trends and Challenges
  - Utilize Technology to Store Completed Applications, Forms and Medical Records
  - File Applications and Forms Electronically when Available
- Make Sure the Patient Never has to Provide Data or a Document More than Once
Practice #7b – Utilize Technology

• Coverage Discovery is Vital
  – Determine if Uninsured Patient is Really Uninsured
    • Initial Scrub for both Commercial and Governmental Payers
  – Determine if Uninsured Patient Obtains Coverage
    • Ongoing Scrub for Medicaid and Other Retroactive Governmental Payers
    • Out to at Least 1 year from DOS
  – Technology
Eligibility

POTENTIAL REWARDS
• Understand that Texas:
  – did not Participate in Medicaid Expansion
  – does not have an Adult Spend-Down Program
  – Has the highest uninsured rate in the Country
  – has one of the Lowest Reimbursement Rates in the Country
  – Undocumented Patients are only eligible for Emergency Medicaid
Average Uninsured Rate for the States that Have Expended Medicaid vs the States that Have Not Expended Medicaid as of 2015

- States in orange **did not expand Medicaid**: having an average uninsured rate of **10.89%**
- States in blue **expanded Medicaid**: having an average uninsured rate of **7.43%**
Successful Inpatient Results

• If Follow the Best Practices on Inpatient Accounts, you should expect:
  – 35-50% of Gross Uninsured Categorically Eligible
  – 80-90% of Categorically Eligible Patients Achieve Eligibility
  – 28-45% of Gross Uninsured Total Charges Converted
  – 17% Average Reimbursement (Texas Adult Traditional Medicaid)

• Should convert each $1,000,000 in Gross Uninsured Total Charges to between $47,600 and $76,500 in Reimbursement
  – Typically Direct Reduction to Bad Debt Because of Population
If Follow the Best Practices on ED and Outpatient Accounts, you should expect:

- 8-12% of Gross Uninsured Categorically Eligible
  - Mostly Dependent on Contact and Coverage Discovery
- 85-95% of Categorically Eligible Patients Achieve Eligibility
- 7-11% of Gross Uninsured Total Charges Converted
- 12% Average Reimbursement (Texas Adult Traditional Medicaid)

Should convert each $1,000,000 in Gross Uninsured Total Charges to between $8,400 and $13,200 in Reimbursement

- Also Typically Direct Reduction to Bad Debt Because of Population
POINT OF SERVICES BEST PRACTICES
WHY IS POINT OF SERVICE COLLECTIONS IMPORTANT?
Rising Consumer Responsibility

- Number of Consumer Payments, from 2011 to 2014, Rose 193% Mainly due to High Deductible Plans
- Employer Coverage Deductibles increase 67% from 2010 to 2015
- 24% of Employees Enrolled in High-Deductible Employer Plans in 2015 (In 2006 it was 4%)
- For Employer Sponsored Health Plans in 2015, the Average Deductible was $2,196
- Average Annual Out-of-Pocket Costs Per Patient Rose 230% from 2006 to 2015
- $502 Billion in Hospital-based Uncompensated Care Expenses Since 2000
- ACA’s Cadillac Tax Set to take Effect in 2018 which Could Push More Cost Shifting to Employees
• Hospitals are 60% less likely to receive payment once the Patient Leaves the Hospital
  – *Wall Street Journal*

• Self Pay After Insurance Collections after Discharge are Between 20 and 35%

• True Self Pay Collections after Discharge are Between 1% and 4%
WHAT ARE THE GOALS OF A POINT OF SERVICE COLLECTIONS PROGRAM?
Program Goals

- **Reduce** Cost to Collect
- **Reduce** Uncompensated Care
- **Reduce** Self-pay Receivables
- **Increase** overall Cash Flow
- **Improve** Patient Satisfaction
- **Reduce** patient Confusion
Point of Service Collections

PRACTICES THAT WORK
Practice #1 – Engage at Point of Service

• Engage the Patient
  – Most Critical Practice for Success
  – Engagement must be Professional and Positive to Succeed
  – Most Patients do not Pay at Point of Service because they are Not Asked to Pay

• Engage at all Points of Service
  – Inpatient Financial Counseling
  – Emergency Department (Complying with EMTALA)
  – Outpatient\Clinic Environments
Practice #2 – Allocate the Right People

• Not Everyone will be Right for POS Collections
  – Even if an Employee is a Good Employee for Other Efforts
  – Evaluate Employees Specifically for the POS Effort
  – Make Sure that the Employee Buys into the Effort
• Role Play to Determine if the Right Employee
  – Live Practice\Role Play Sessions
  – Acclimate Employees to the Process and Success
• Consider Incentivizing the POS Collectors
Practice #3 – Have the Right Information

• Empower POS Collectors with Comprehensive Patient Billing Information
  – A Patient will not Pay unless:
    • There is a Clear Understanding of How Much is Owed; and
    • Why the Money is Owed
  – Ensure Patient Informed of Cost Before Service, where Possible

• Technology Tools
  – Payment Estimation Tools
  – Coverage Verification Tools
MAYBE IF YOU TRIED ANOTHER CARD...

THE H.M.O. SURGICAL PROCEDURE
Practice #3 – Script for Success

• Do Not Leave the Approach to the Employees
• Prepare POS Collections Bundles for Each Area of Interaction
• Script Interactions using the 4 “C”s
  – Confident
  – Competent
  – Compassionate
  – Collaborative
• Monitor POS Collection Employees for Script Compliance and Proficiency
  – Be Aware of Employee Burn-out
  – Be Aware a Difficult Effort
Practice #4 – Provide Options

• Do Not Give the Patient a Reason to Say “No”
• Provide Options for:
  – Amount:
    • Try Total Amount Due
    • Try Discounted Price
    • Try Payment Plans
  – Method of Payment
    • Cash
      – Make Sure there is an ATM Available
      – Have Proper Policies for Cash Management
    • Check
    • Credit Card
    • Payment Plans
• Make the Options Quick and Efficient
Practice #5 - Obtain Buy-In

- POS Collections is Not Sexy or Fun
- Make Sure that there is Comprehensive Buy-In
  - Hospital Executives
  - Clinical Staff (Doctors and Nurses)
  - Financial Departments
  - Admissions
  - Case Management\Financial Counselors
- Especially During Implementation Buy-In is Critical
Point of Service Collections

POTENTIAL REWARDS
Successful POS Collections Results

• General Positive Results
  – Reduced Cost to Collect
  – Reduced Uncompensated Care
  – Reduced Self-pay Receivables and A/R Days
  – Increased Cash
  – Potentially Improved Patient Satisfaction
Successful POS Collections Results

- Specific Results are Very Hard to Quantify
  - HFMA Top POS Collections Performers for 2014:
    - POS Collections = 39% of Total Self Pay Cash Collected for Individual Hospitals
    - POS Collections = 27% of Total Self Pay Cash Collected for Large Systems
  - Specific to Each Facility and Population
  - Need to Understand Facility Baseline and Plan from That Point
QUESTIONS
• Douglas Turek
  – MedData (formerly Cardon Outreach and Alegis)
  – douglas.turek@meddata.com
  – 832-489-4939