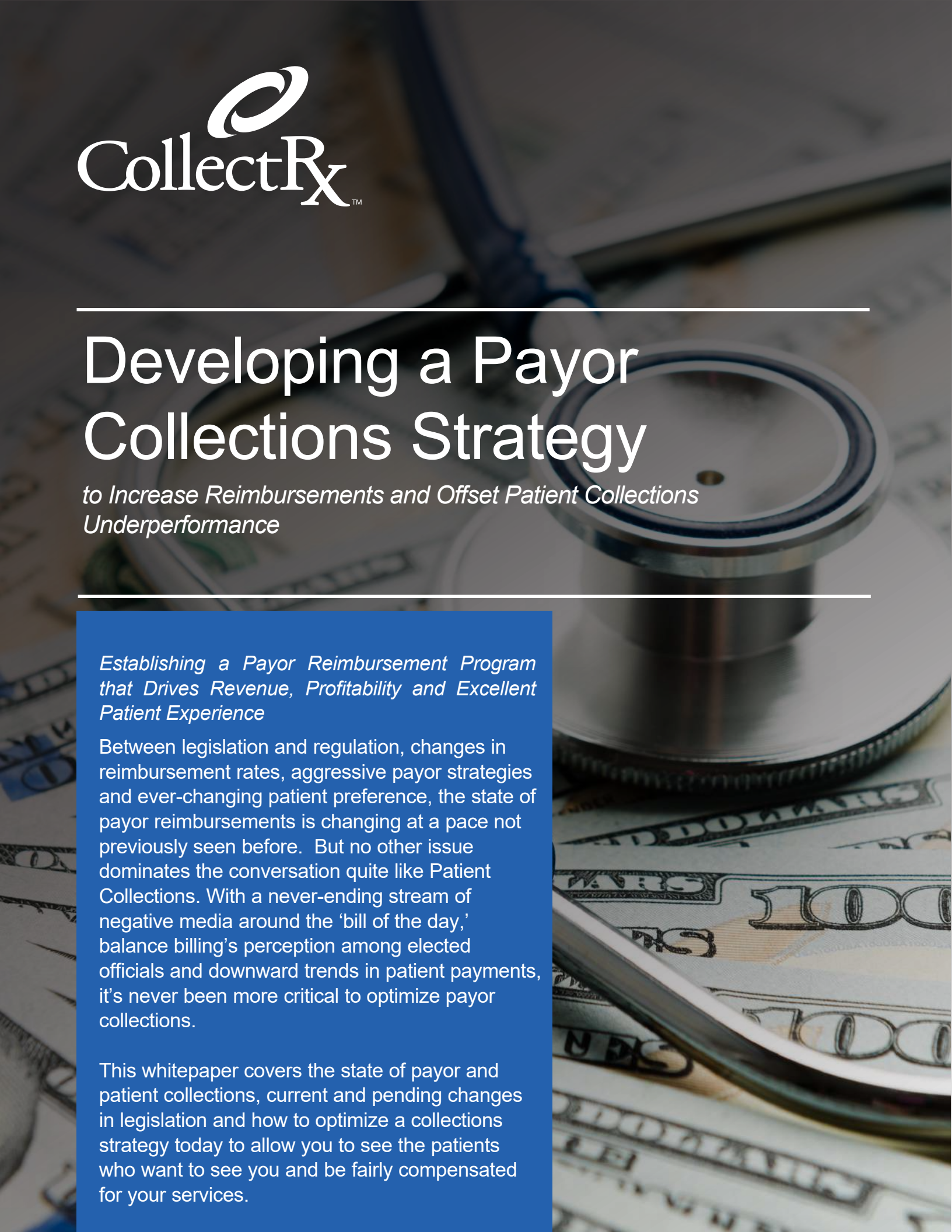


CollectRx™

Developing a Payor Collections Strategy

to Increase Reimbursements and Offset Patient Collections Underperformance

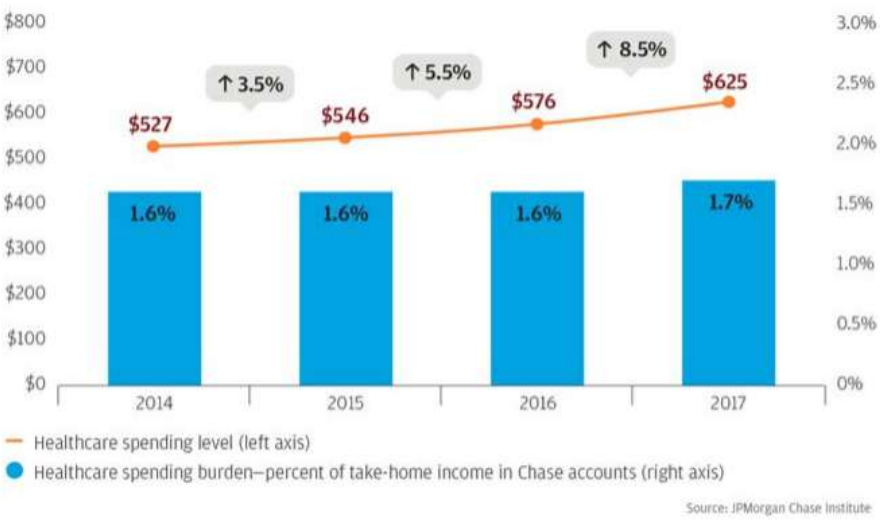
Establishing a Payor Reimbursement Program that Drives Revenue, Profitability and Excellent Patient Experience

Between legislation and regulation, changes in reimbursement rates, aggressive payor strategies and ever-changing patient preference, the state of payor reimbursements is changing at a pace not previously seen before. But no other issue dominates the conversation quite like Patient Collections. With a never-ending stream of negative media around the 'bill of the day,' balance billing's perception among elected officials and downward trends in patient payments, it's never been more critical to optimize payor collections.

This whitepaper covers the state of payor and patient collections, current and pending changes in legislation and how to optimize a collections strategy today to allow you to see the patients who want to see you and be fairly compensated for your services.

Current Trends in Patient Collections

Average annual out-of-pocket healthcare spending level grew faster in 2017, while healthcare spending burden ticked up slightly.



Average out of pocket expenditure is increasing quickly[1]

Setting the stage, let's look at the macro-level issues around the cost of healthcare and the shift in the burden of payment.

A recent JPMorgan Chase Institute study shows that out-of-pocket healthcare spending increased 8.5 percent between 2016 and 2017, the fastest growth occurring over the last three years.

Additionally, the overall burden on patients has increased significantly:

- Today's average deductible is nearly $2,000, and the average maximum out-of-pocket is nearly $4,500[2]
- 30% of the average healthcare bill now comes directly from the patient's pocket
- Among people with health insurance, one in five (20%) working-age Americans report having problems paying medical bills in the past year[3]

This puts providers in a difficult position of having to collect more of their patients' hard-earned income while still trying to maintain the doctor-patient relationship.

Impact to Hospitals & Ambulatory Surgery Centers

At the same time as we've seen a substantial increase in patient responsibility, surgery expenses have surged. From 2012 to 2016, outpatient surgery prices increased 19%. Patients are increasingly focused on cost, and according to InstaMed, 65% indicate they would consider switching healthcare providers for a better payment experience.[4]

There is also a communication disconnect between patients and providers. Providers are struggling to address patient needs regarding cost expectations. West Corp. data indicates that 3 out of 4 patients say they do not know the cost of their healthcare services until they receive a bill.[4]

Despite the growing demand from patients for more information about their medical care expenses, providers are coming up short in meeting these needs, resulting in almost 30% delaying medical payments because of confusion over what expenses were covered by insurance and what they owe.

Most worrying, patients are experiencing significant, negative effects on their health and financial wellbeing. University of Chicago's NORC states that up to 40% of people skip necessary medical tests or treatment due to costs, 28% of patients had a medical bill turned over to a collection agency and 37% of consumers have unpaid debt from medical bills.[4]

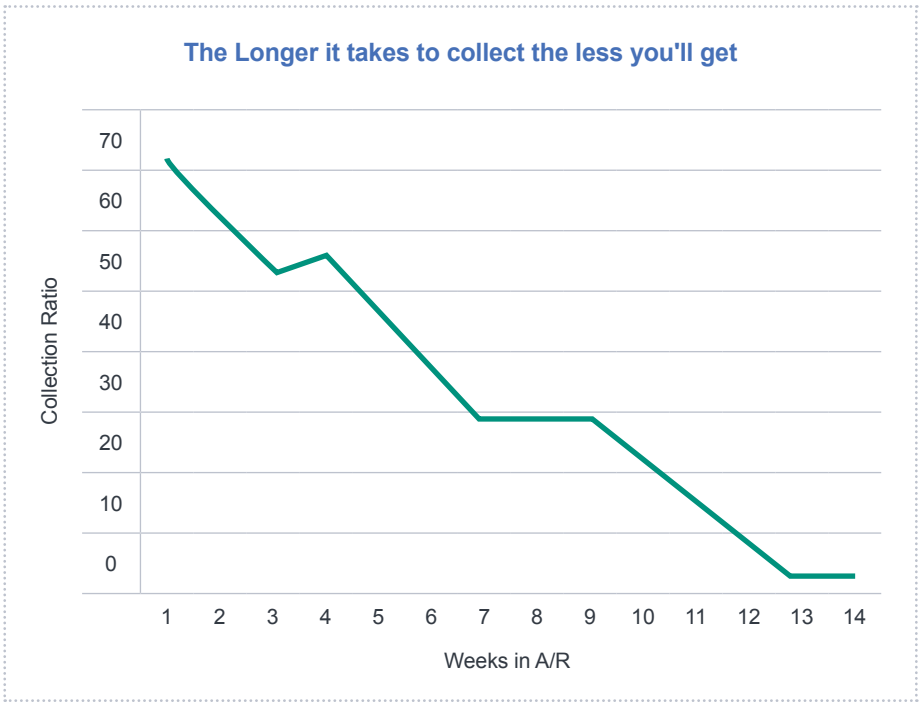
2 in 3 Patients
Don't Pay Their Hospital Bills in Full

All this leads to issues with payment and collections. According to a report from Transunion, a significant percentage of bills are not getting paid.[5]

63% of hospital bills were $500 or less; of those, 68% were not paid in full

10% of hospital bills were $500 to $1,000; of those, 85% were not paid in full

4% of hospital bills were $3,000 or more; of those, 99% were not paid in full[5]



Patient balances are getting harder to collect, and as the days outstanding increase, the chances of collecting go down.[6]

- 65% of bad debt belongs to insured patients
- the average recovery rate for a medical practice's bad debt is 21.8%
- 1 in 5 insured Americans encounter problems paying medical bills

Not only are the success rates falling with patient collections, the costs are increasing. According to Insurance News Network, it costs a provider four times more to pursue debt collections from a patient than a payor.[7]

Traditional Collections Methods
Aren't Working

The current systems and processes for collections are underperforming. Survey findings from Black Book of 1,595 physician practices, 202 hospitals and 49 health systems reveal that the current methods for collecting from patients just aren't working.

- Profit margins continue to be impacted negatively by traditional collection solutions
- 82 percent of medical providers and 92 percent of hospitals plan to jettison time-intensive, error-prone, manual efforts to back end process and reconcile bills.[8]

Hospital Bad Debt Rises With Growing Share of Patient Financial Responsibility

According to another new analysis from TransUnion Healthcare, with patient payment representing a growing share of health systems' revenue, consumers and providers are being put in a more and more precarious position.

- Hospitals continue to face financial challenges as the landscape shifts, and the challenge posed by patient balances after insurance, or PBAI, is growing.
- PBAI rose from **8%** of the total bill responsibility during Q1 2012 to **12.2%** during the same quarter in 2017.

Between the growing share of patient financial responsibility and the high cost of collections with its low success rates, patient collections contribution to Hospital bad debt is continuing to grow.[9]

Negative Impact on Patient Experience and Loyalty

Finally, don't forget how negative billing interactions affect payment. Patients who are very dissatisfied with Business Office interactions are more likely not to pay their bill willingly.

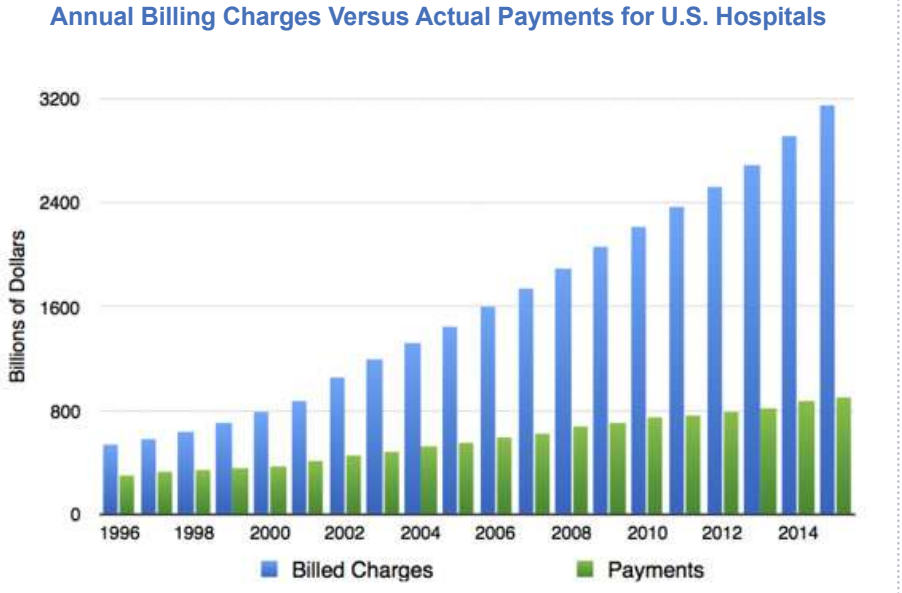
- More than 50 percent of patients indicate that out-of-pocket costs will have significant or highly significant influence on provider choice
- Out-of-pocket costs affect provider selection. More than 50 percent of patients indicate that out-of-pocket costs will have significant or highly significant influence on provider choice.[10]

Trends in Payor Reimbursement

The past few years have been turbulent for providers and payors, and sometimes it helps to take a step back and see how the issues that most providers face on a daily basis are simply reflective of some macro – level trends in healthcare and reimbursement.

#1 Issue
Facing Providers

- Historic Downward Trend in Reimbursements
- Across All Payors
- 20-50% Average Payments vs. Billed Charges



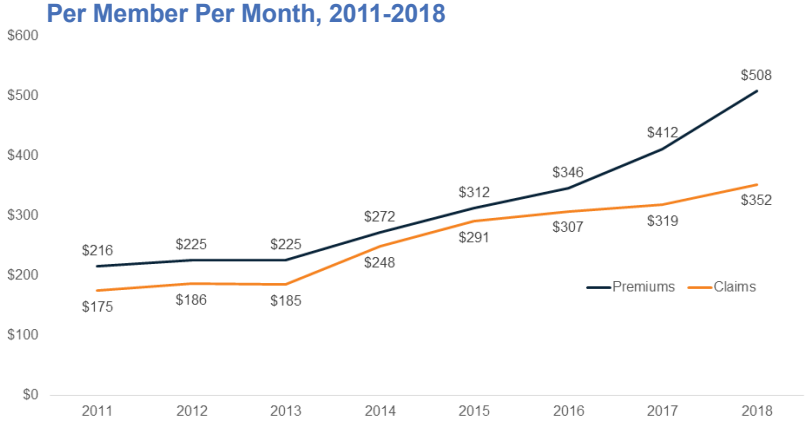
Far and away, the number one issue that providers face is the reduction in reimbursements as a percentage of billed charges. It is important to remember that the payors (and the vendors who work for the payors) are working continually to reduce reimbursements and underpay claims.[11]

Today payors are using a variety of "tactics" which allow them to reimburse providers at between 20 and 50% of billed charges. These tactics are largely successful, resulting in a significantly lower pay out to providers for services they are delivering to the payor's subscribers.

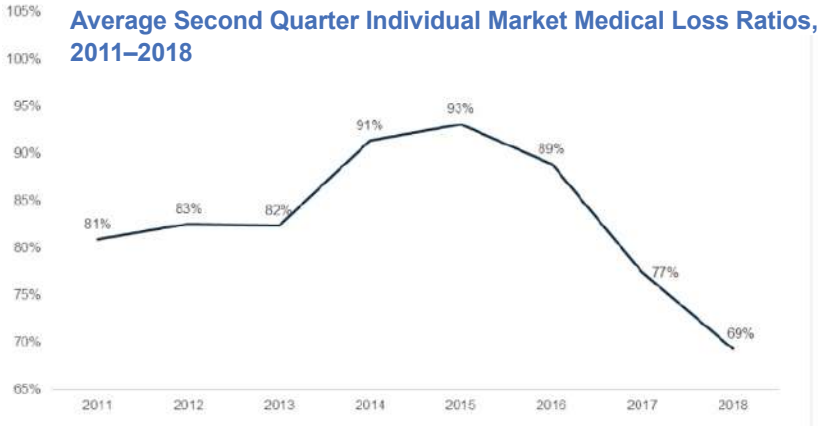
Medical Loss Ratio

On average, second quarter premiums per member grew 23% from 2017 to 2018, while per member claims grew only 10%.

Average Second Quarter Individual Market Premiums and Claims Per Member Per Month, 2011-2018



Average Second Quarter Individual Market Medical Loss Ratios, 2011–2018



There is a growing gap in the individual market between premiums collected and claims per member from 2011 through 2018.[12]

While both are growing at a healthy clip, the last two years have seen a marked divergence between the premiums and payments to providers. Simply put, the payors are not compensating providers at the same rates they are increasing premiums.

Medical Loss ratios began to decline in 2016 and continued through 2017 and 2018, partially due to relatively large premium increases. Loss ratios have continued to decline, averaging 69% in the first six months of 2018.[13]

The data analyzed relates to the individual market, where there is an actual requirement to not go below 80% medical loss ratio or be forced to rebate premiums. In the non-ACA payor marketplace, there is no such requirement.

Denials

In some startling statistics, claims denials are big business for payors:

- The Department of Labor estimates that one in seven claims is rejected, or the equivalent of 200 million denials a day. There are any number of reasons why this is occurring, but at the end of the day, providers and patients are left holding the bag on 14% of claims.[16]
- The Office of the Inspector General for Health and Human Services recently delivered a scathing report of denials for Medicare Advantage plans, noting that appealing pays off tremendously. Only 1% of denials are appealed, but of those that are, 75% are successful.[14]
- Similarly ACA plans, with almost 1 in 5 claims denied, show only 200,000 of the 43 million denials ever being appealed. An average of nearly 1 in 5 in-network claims were denied in 2017, with denial rates ranging from 1% to more than 40% across insurers.[15]
- A Change Healthcare analysis says its data shows that of an estimated $3 trillion in claims submitted by hospitals in 2016, an estimated 9% of charges were initially denied. And even though the same data show that up to 63% of denied claims are recoverable on average, representing $262 billion in revenue, it may cost hospitals and health systems nearly $9 billion more in administrative costs to recover that money.[17]

Reasons cited for not appealing?

Complexity of the Appeals process

Cost to Appeal

Lack of Time and Expertise

Legislative Update

In addition to the challenges in patient and payor collections, there are some trends on the legislative and regulatory front that have the potential to change the reimbursement landscape. Particularly, legislation around 'surprise bills' and balance billing has been gathering steam at the state and federal level. It is important to understand, however, how these laws are targeting very specific instances rather than the broader out-of-network space.

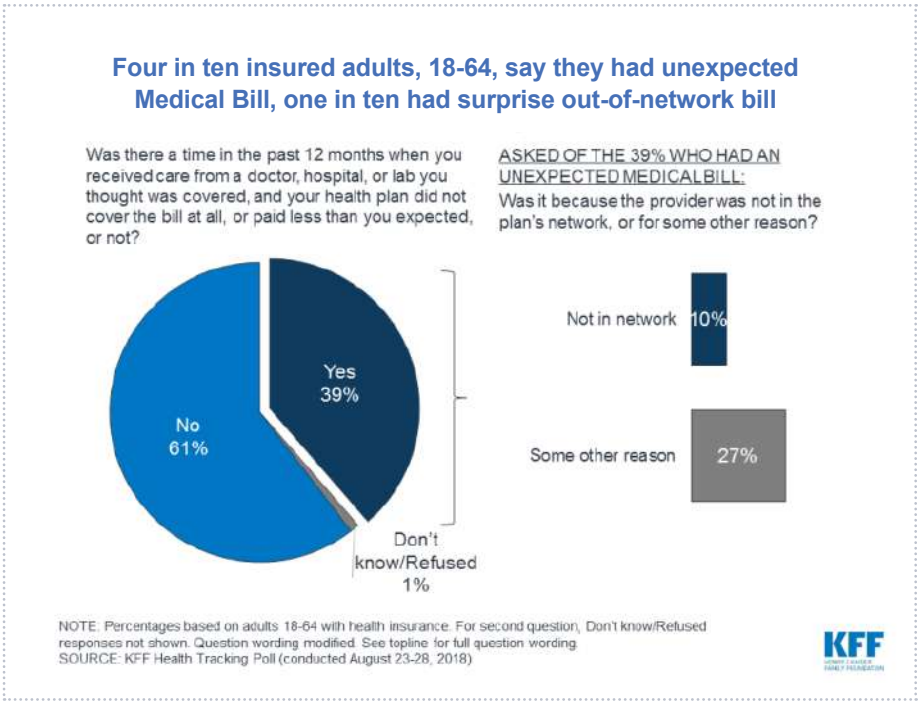
Surprise Bills

Most surprise medical bills arise from very specific situations:

- An insured individual inadvertently receives care from an OON provider, for example in the Emergency Department

OR

- A patient receives care from an in-network facility or provider with an out-of-network provider providing ancillary services, for example, an out-of-network anesthesiologist at an in-network facility.



Everybody's heard about the issues with "Surprise Bills". They have an outsized impact on patients.

- For patients, when given a list of possible worries, unexpected medical bills tops the list that includes other healthcare costs such as premiums, deductibles and even drug costs.
- Four in ten insured adults ages 18-64 say there has been a time in the past 12 months when they received an unexpected medical bill and one in ten say they received a "surprise" medical bill from an out-of-network provider in the past year.[18]

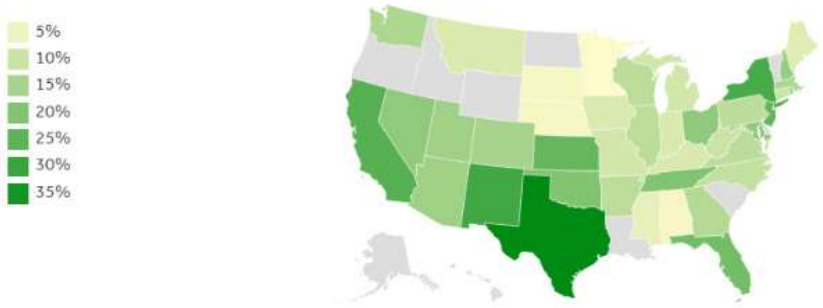
As a result, a variety of legislative actions have been introduced designed to remove the patient from the payment process, and put claims issues between the provider and the payor. They're one main reason why getting a clear idea of how to manage your billing when the patient is not involved will become more and more important in 2020 and beyond.

In an emergency setting, patients are often unable to ensure they go to an in-network emergency room. The Affordable Care Act (ACA) provides partial protection for patients receiving out-of-network emergency care. The ACA requires all non-grandfathered health plans to cover out-of-network emergency services and to apply the in-network level of cost sharing to such services. However, the ACA does not prohibit balance billing by facilities or providers for emergency care. As a result, patients can and do receive surprise bills for emergency care from the emergency room facility and from providers who treat the patient in the ER.

Of the emergency room visits in 2017 by people with large employer coverage, it is estimated 18% had at least one out-of-network charge (from either the facility, the provider, or both) associated with the visit. This includes out-of-network charges from the emergency facility, emergency room providers, and provider and facility charges associated with a resulting inpatient stay, when applicable.[19]

On average, 18% of emergency visits result in at least one-of-network charge, but the rate varies by state

Among people with large employer coverage, the share of emergency visits with a least one out-of-network charge, 2017



States shaded gray have insufficient data

Source: KFF analysis of IBM Marketscan 2017 data • Get the data • PNG

An unexpected bill from an out-of-network provider can be stressful. However, insurers believe that narrow or “skinny” networks are necessary to reduce cost, so as they continue to pursue narrowing networks in an attempt to maintain their profit margins, more and more patients seeking emergency care will receive a surprise bill.

State Legislation

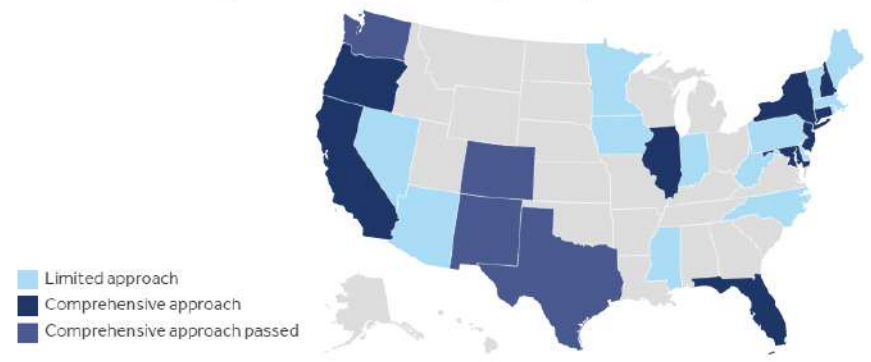
A number of states have enacted laws to protect some patients from surprise medical bills.

Up to nine states have enacted and implemented laws taking a comprehensive approach to surprise bills (California, Connecticut, Florida, Illinois, Maryland, New Hampshire, New Jersey, New York, and Oregon).

Four more states – New Mexico, Washington, Colorado, and Texas – enacted new surprise medical bill laws that take effect through 2019.[20]

The comprehensive state laws share common features:

State balance billing protections for state-regulated plans



Note: Four states have passed comprehensive protections that have not yet gone into effect as of June 2019

Source: See Jack Hoadley, Kevin Lucia, and Maanasa Kona, "State Efforts to Protect Consumers from Balance Billing" for summary of state laws enacted through 2018. Updated by KFF to reflect action as of June 2019.
• Get the data • PNG

- Hold patients harmless: Comprehensive state laws hold consumers harmless against surprise medical bills. In addition, laws prohibit providers from balance billing patients covered by state-regulated plans; instead, the out-of-network provider is limited to collect no more than the applicable in-network cost-sharing amount from patients in cases of surprise medical bills, based on either usual and customer charges or benchmark rates.
- Resolve payment for surprise bills: Approaches vary, with some states adopting a payment standard for all applicable surprise medical bills, while other states establish a dispute resolution process that insurers and providers can use to arrive at a payment amount for each surprise medical bill. Some states are using a combination of both approaches.
- Contain limits to state law protections because of federal pre-emption: All states have limited jurisdiction to protect privately insured residents from surprise medical bills due to the Employee Retirement Income Security Act of 1974, or ERISA. These state laws generally do not apply to people with large employer coverage whose employers self-insure, as these plans are covered under ERISA.

Federal legislation

Because ERISA preempts states' abilities to regulate self-insured plans, thereby limiting the scope of the state laws, federal action is necessary to address certain aspects of surprise bills for people enrolled in these plans. Legislation is expected to be passed in fall of 2019.

There are two comprehensive bills under consideration at the federal level, and five additional that address aspects of surprise billing specifically. Legislators have also included provisions to address surprise medical billing in several, broader healthcare bills, such as the legislation introducing Medicare for America.

Each of these bills have much in common. Lawmakers agree that patients must be protected during the settlement process for a surprise medical bill and that they should only be liable for what their responsibility would be at an in-network facility or with an in-network provider. They also agree that any legislation should apply to any healthcare facility or payer type, thus protecting all patients.

For both state and federal initiatives, there are some key takeaways:

- All proposed legislation includes a prohibition on balance billing patients.
- Many of the state and federal proposed bills include provisions for negotiation using usual and customary rates as a basis
- Most legislation is specific to emergency and ancillary providers
- Arbitration clauses included in many of the proposed bills is considered favorable to providers
- While the benchmarking approach is favored by the payors, the indexing against usual and customary is much more aligned to the current approach and seems to be included in more of the state initiatives.

Best Practices in Payor Collections

Given all of this, what is the best practice for you to ensure that your collections are most effective?

You need to ensure that your payor collections strategy is in place and working well. Given the trends in the market, it is highly recommended to focus efforts on collecting from payors rather than patients, and here are our top 10 best practices that can help you do that.

1. Analyze every denied claim, partial payment and non-payment to recover additional reimbursements: The first best practice is to analyze every account to ensure you've maximized your reimbursement. It may seem obvious, but with the complexity of the reimbursement environment as well as billing systems, ensuring that you are touching every claim to verify that it has been paid at the correct, appropriate and most importantly, highest rate, is critical to maximizing your payor reimbursements.

2. Leverage technology to acquire data from payor websites to ensure you can reconcile every account to zero: Analyzing every claim is extremely challenging when you're using either your billing system alone or manual approaches. By implementing technology that acquires data from the payor websites, you can quickly and easily automate your workflows with real data in real time rather than relying on spreadsheets and manual data entry to ensure you've received the correct payments.

3. Identify, prioritize and assign at – risk accounts before they are denied, underpaid or delayed: Best Practice number three relates to the use of data and technology to ensure that you look at every claim, every time. When you use technology to help manage the payor reimbursement process, you are able to quickly identify and prioritize at-risk accounts before they become a problem by targeting indicators that typically result in issues early. Then, you can leverage workflow technology to assign each for follow up, thus ensuring that nothing falls through the cracks or is missed due to oversight.

4. Leverage data to uncover root causes of denials, underpayments and delayed payment: Claims denials, underpayments and delays may be a part of life for healthcare revenue cycle managers, but a prevention-focused denials management strategy can significantly reduce the number of times billing staff are faced with unpaid claims. You can drill down into your data on unpaid claims to discover root causes and implement targeted fixes that can improve your revenue profile significantly.

5. Quick review, correction, and resubmission of denied claims to prevent further delays: The Medical Group Management Association (MGMA) found that approximately 65 percent of claim denials were never corrected and re-submitted to payers for reimbursement.[21] Put processes and automated technology tools in place to immediately identify denials and resubmit as quickly as possible.

6. Negotiate additional payments when a payor re-prices a bill or doesn't pay at all with a rigorous appeals process: Best practice #6 focuses on actually appealing claims. When the insurance company re-prices an out-of-network bill down to what they consider to be reasonable and customary, which is typically close to the Medicare rate, you need to appeal that payment. From their perspective, the insurance company takes the position that they have met their obligation in paying the bill. You need to appeal by leveraging data and expertise in working with payors to back up your stance that their payment was not reasonable. Rigor is the key here, as they have an entire playbook dedicated to continuing to roadblock your efforts.

7. Leverage historic data on payor negotiations to negotiate from a position of strength: The key to success in negotiating with payors is to leverage historic data. You need to be able to present a compelling case and showing them data that demonstrates that they have paid at a higher rate is critical.

8. Reconcile first payments, additional payments and patient payments with the original claim: Best practice number 8 is to Reconcile. When you implement a rigorous payor reimbursement system, that includes appealing claims for additional payments, it's critical that you reconcile first and additional payments with the initial claim, to ensure that you are receiving the highest reimbursement, for tracking and data analysis purposes.

9. Reconcile every account from assignment to zero balance Best practice #9 is again reconciliation, but in this case, it's ensuring that you track every account. For each account, not only the ones that have multiple payments, it is critical to reconcile from assignment to zero balance. This provides the data that you need to allow you to evaluate the success of your program, evaluating your collections across multiple facets, from payor to CPT code to collector. This data is key to identifying bottlenecks and weak points, and helping you to optimize your entire revenue cycle.

10. Consider outsourcing some components of your AR and Collections to experts. Finally, best practice number 10. Outsourced solutions are more and more common, and on the rise, according to a Black Book report.[22]

Approximately 83 percent of hospitals currently outsource some accounts receivable and collections, while 68 percent of physician groups with ten or more practitioners outsource a combination of collections and claims management. Particularly when it comes to complex claims and the pace of change in healthcare billing, leveraging expertise maximizes your chances of significantly improving your bottom line.

Payor Reimbursement Program

So putting it all together, what is a Payor Reimbursement Program?

A Payor Reimbursement Program is a clear strategy to manage payor denials, delays and underpayments across claims types. It is simply the strategy, tools, processes and metrics that ensures you collect the maximum reimbursements from your payors:

- In a timely manner
- That reduces your AR
- That increases your reimbursements for all claims types

There four major components to a robust payor collections strategy that let you maximize your reimbursements and shift your strategy from patient to payor collections, aligned with your revenue cycle.

Patient Access

Maximizing revenue starts with the most effective patient access processes and understanding how to optimize both the front-end of your business as well as your patient experience and collections. The goals at this stage is to improve your accuracy, reduce denials downstream, improve your financials with an integrated Revenue Cycle Management approach.

Billing & Coding

Maximize claims revenue, increase total reimbursements and reduce denials and underpayments by ensuring your claims are coded and submitted correctly. Medical Coding is becoming more and more complex and without the resources that can navigate as the industry changes, you run the risk of reduced payments across all payors. Focus on increasing your expertise, technology, data and processes to enhance accuracy and efficiency, and reduce billing errors and unpaid claims. Your program should include Coding & Document Review, Charge Entry & Reconciliation and Billing & Claims Processing.

Collections

This is really where the heavy lifting with any Payor Reimbursement Program lies. No matter your claim type, you need to be able to work across all payors to ensure that every claim is reviewed, denials and underpayments appealed and the first and additional payments reconciled to ensure that you are getting the payments you're entitled to. The goals at this stage are to increase cash collections, automate processes, reduce your AR days, and ensure that each claim is paid at the highest rate. The goal is to get all your claims paid correctly, completely and on – time. Your program should include AR Follow Up, Denials Management, Appeals, Out–of–network Negotiations and Payment Posting & Balancing.

Data, reporting and Analytics

Ensure that your billing department is data-driven, and is able to address the challenges of the most complex claims. Insist on leveraging data, reporting and analytics to understand your revenue cycle and provide the right recommendations to help you maximize your collections. Build easy to understand intuitive reports and dashboards that provide a real time window into your billings and ensure you are able to understand the current situation and plan for the future.

Standard reports:

Create a set of metrics and KPI's at the high level, that let you keep your eye on data points that would show issues or problems that you need to dive on immediately.

Enhanced reporting:

These metrics are the deep dive that you want to be able to get your hands on quickly when you need to dig into an underperformance, as well as those that will show you the biggest area of opportunity when regularly reviewed. Identify those areas that have the greatest risk for you, for example a particular code or payor that a significant percentage of your revenue comes from, and set up reports that will alert you immediately when there is a variance from your historic trends or forward projections. .

Analytics:

Make sure you have the ability to dig into the data yourself. Being able to run reports on the fly when you notice an issue and get to the problem or opportunity is critical to maximizing your collections.

Full Cycle Revenue Integrity

Keep your focus on AR, collections and payment reconciliation, aligned to your front and back office processes to help you to obtain a higher clean claim rate, proactively identify and resolve issues that result in underpayments and denials and optimize your revenue and financial results.

Complex Claims and Out-of-Network Expertise

Lastly, as the reimbursement environment becomes more challenging, you need to build your expertise in fighting the payors for the reimbursements you deserve. Partner with somebody who understand the tactics they use to reduce payments to providers, and has the tools, technology, processes and know-how to combat them to ensure you receive the reimbursements you are entitled to.

Payor Reimbursement Program

Lets You...

- **Increase Reimbursements and Maximize Cash-to-Revenue**
- **Optimize Every Transaction**
- **Reduce Days Outstanding**
- **Decrease Cost to Collect**
- **Improve Upstream Processes Using Data and Analytics**
- **Manage Complex Claims and Improve Patient Experience**

To summarize, a robust payor collections program has a number of tangible benefits to your organization and clients.

First, a program that leverages best practices will increase reimbursements and combat the decline in rates and the ability to collect from patients.

Second, it will allow you to optimize every transaction, and ensure that you are getting the payments you're entitled to from payors.

Third, it will allow you to maximize cash-to-revenue, decrease collections costs, and reduce days outstanding. The data and analytics will allow you to improve processes upstream, and help you manage your complex claims.

Fourth and perhaps most importantly, it will improve patient experience as the payors become more accountable and meet their obligations.

When done right, proper payor reimbursement management and collections is one of the only way providers can improve financial performance.

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COLLECT RX

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Chief Executive Officer

John Bartos is a veteran in the field of healthcare and information technology. As President of DrFirst, Inc. and Executive Vice President of Prematics, Inc., Mr. Bartos has specialized in providing cost containment services to health insurers and various products and services to hospitals, health systems, and other healthcare providers. Previously, Mr. Bartos was an attorney at Kirkpatrick & Lockhart, LLP (now K&L Gates), where his practice focused on litigation.

Mr. Bartos' clients have included a wide range of for-profit and not-for-profit health insurers, including Blue Cross Blue Shield of Florida, Humana, Capital BlueCross, Kaiser Permanente of the Mid-Atlantic Region, CareFirst, and BlueCross BlueShield of Massachusetts. Mr. Bartos has also worked on behalf of numerous hospitals and health systems, including Henry Ford Health System and MedStar Health, along with hundreds of physician practices.

Mr. Bartos is a graduate of Princeton University and received his J.D. from the American University Washington College of Law, where he graduated Summa Cum Laude and was a member of Law Review.

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