Speed to Revenue: Personalizing the Patient Financial Experience

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Meet the Presenter

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VP Hospital Operations
Agenda

• Our Challenge
• St. Luke’s Patient Financial Landscape
• Significant Patient Access and Collections Challenges
• St. Luke’s Initiative Goals
• The Beginning Discovery and Initiatives
• Using information to better understand our patients
• Payment plans and patient behavior
• Innovative Tactics for Improvement
• Strategic Impact
• Lessons Learned
The Patient as a Consumer

Patients are taking a more proactive approach to their healthcare as a result of rising out-of-pocket expenses:

- Higher deductibles
- Increased medical costs
- Increased out-of-network fees
The Shifting Healthcare Financial Landscape

Healthcare Provider Challenge

Healthcare organizations are searching for new solutions to meet the demands of patient guarantors while:

- Wrestling for market share
- Competing to retain patients
- Seeking to differentiate by providing a superior consumer experience

MEDICAL BILL RESPONSIBILITY

% of Patient Responsibility  % of Insurance Responsibility

<table>
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<tr>
<th>Year</th>
<th>2000</th>
<th>2005</th>
<th>2010</th>
<th>2015</th>
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<tr>
<td>%</td>
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<td>90%</td>
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<td>80%</td>
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<td>%</td>
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<td>15%</td>
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Source: Forbes
The Shifting Healthcare Financial Landscape

- Employer-sponsored family premium costs rise 5% to $20K avg
- Nearly a quarter of insured have a $2K or greater deductible
- Nearly two-thirds of US households have less than $1K in savings

Sources: Henry J Kaiser Family Foundation; The Tennessean
The Patient’s Out of Pocket

- Out-of-pocket costs for inpatient services increased by 14% on average between 2017 and 2018
- Patients' deductibles and co-pays averaged $4,659 for an inpatient visit in 2018, compared with $4,086 in 2017

Source: TransUnion Healthcare

Source: The Office of the Actuary in the Centers for Medicare & Medicaid Services, 2019
Introduction to Montefiore St. Luke’s Cornwall

- 242-bed, not-for-profit system
- 300 referring physicians on staff, representing dozens of medical specialties
- Serving over 270,000 patients from around the Hudson Valley
- Campuses in Cornwall & Newburgh, NY
Significant Patient Access and Collections Challenges

- Cash collections too low and slow
- Patient registration process too time consuming
- Limited point-of-service (POS) collection goals for staff at the individual or group level (tracked only by service type)
- Lack of understanding of why we do what we do
St. Luke’s Initiative Goals

1. Increase collections, especially at POS. Take advantage all available data to better understand our patient’s financial standing

2. Enhance patient financial services satisfaction scores to match high satisfaction levels with St. Luke’s clinical services

3. Normalize pre-registration process for all outpatient departments

4. Decrease registration wait times, no-shows and cancellations

5. Collect and analyze patient data for those who fail to meet appointments to identify changes based on the patterns shown
Current State Discovery

- Staff Interview
- Staff Observation
- Data Review
Using Data to Better Understand your Patient

• Harness the power of all the information available to you to get a clearer picture of your patient’s financial standing
• Solutions on the market that distill propensity to pay information to simple financial score
• Easy for staff to understand and use operationally
• Create payment plans that a patient can bare
• Studies by early out servicers indicate better payment compliance when amount due is manageable even if the duration is increased
Cultural Change

- Patients need to know patient access processes have been completely transformed to change their experience for the better
- Clinical staff must be fully informed, and a clinical champion appointed for provider to provider discussions
- Engage front-end staff to spread the word; they make great change agents
Critical Steps for Change

1. Leadership buy-in – (top down project)
2. Design and implement patient-friendly pre-access system model to include:
   - Consolidation of central scheduling
   - Streamline workflows across departments
   - Develop custom financial guidance and planning
   - Expansion of staff roles to cover registration and financial services responsibilities
Automated Systems with Best-Practice Workflows

- Automate and streamline workflows specific to patient needs by implementing people and technology systems
- Create short, simple, task specific workflows to get higher compliance
- Introduce automation where necessary but don’t over complicate workflows (just so you can automate)

WORKFLOW

Communication  Planning  Strategy  Documentation
Automated Systems with Best-Practice Workflows

Benefits:

• Estimates accurate patient out-of-pocket obligations, with real-time features that pinpoint the amount of patients’ deductibles met to date
• Offers payment plan options tailored to each patient’s budget and ability to pay
• Connects uninsured patients with financial assistance programs, when appropriate
Pre-Access Registration Processes Design

- Contact patients by phone at least three days prior to appointments (usually 3-5 days from scheduled day)
- Verify insurance information, deductibles and copayments
- Run billing estimates and assess patient ability to pay using automated tools powered by real-time data. Using information to create personalized payment plans and securing payment prior to service date
- Determine the most appropriate payment options and generate a customized financial care plan
- Pre-register patients for all approved services
Pre-Access Registration Processes Design

To reduce lobby wait times, appointment cancellations and speed patients to their clinical destination by completing all or most of the process before the patient visit.

• No-stop status: The patient has pre-registered and cleared to proceed directly to the patient care area upon arrival

• Quick-stop status: The patient has pre-registered but has chosen to pay a copayment on the day of service rather than in advance

• Full-stop status: The patient must complete the entire six-step process before proceeding to the patient care area
Accountability and Continuous Improvement

Capture and monitor productivity reports that measure individual and team performance, including the following:

- A daily activity report showing all transactions for that day
- POS collections report, including missed opportunities
- An eligibility report for both active and inactive eligibility results
## Strategic Impact

### Results of Montefiore St. Luke's Patient Access Transformational Initiative

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<td>Point-of-Service Cash Collections: Monthly averages (in dollars)</td>
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<td>Authorizations: Daily per FTE</td>
<td>Not captured</td>
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Lessons Learned

How can your organization support a better patient access experience while boosting point-of-service collections?

1. Gain support from the top down
2. Invest in education for all patient financial services staff, patients, nurses and physicians
3. Define metrics for success, capture data to support them and make performance results highly visible
4. Reward employees for high performance
5. Continuous Education, the journey never ends
What’s Next? PatientMatters Prior Authorization (PA)

• Annually, 265M claims require PA and PA volume is increasing 20%+ per year
• PAs and denials were one of the top concerns for hospital CFOs in 2019 and will continue to be in 2020
• Phone and fax are still the most commonly used method for PAs – we can do better
• 7 in 10 physicians state they find it difficult to determine if a medical service requires PA
• A provider requests an average of 15.1 PAs for medical services each week and it takes an average of 14.6 hours to complete the requests
• Physicians experience greater than 20% rejection rate from insurers on first-time PA requests.
• PA issues contribute to 92% of all care delays

Source: “Patient Clinical Outcomes Shortchanged by Prior Authorization,” AMA Survey, Mar 2018
Source: “Prior Authorization Issues,” HealthPayer Intelligence, Mar 2018
Source: “The Impact of Prior Authorizations,” Medical Economics, Feb 2019
Why Prior Authorization is Critical for Financial Health

Three-Step Prior Authorization Process

1. **Is Authorization Required?**
   - Determine if an authorization is required for the patient's scheduled service

2. **Determine Authorization Request**
   - If an authorization is required, authorization request is submitted to payer

3. **Authorization Status**
   - Upon completion of the authorization request, check / rechecks for status begin

**Source:** Triple Tree Analysis
How PatientMatters Supports Prior Authorization

- Reduce time to authorization by taking the guess work out of the process – only work accounts that need authorization
- Reduce labor costs - streamlined workflow creates higher productivity
- Simple workflow and with minimal training
- Compatible with all EMRs; authorization status pre-populated via HL7 eliminating data entry
- Dedicated authorization advisor
- Quick implementation – 90 days from contract
- Rules and payer requirements maintained by PatientMatters
- Great fit into the Pre-Access model workflow
- Prevent/decrease denials for no or inaccurate auth
- Provides reference guides to appeal cases
Additional Resources

RCM Answers, June 19, 2019
Costly Decisions: How Rising Healthcare Costs Affect Patients and Providers

RevCycleIntelligence, May 20, 2019
Pre-Access Center Collects More Patient Financial Responsibility

Healthcare Business Today, February 7, 2019
Moving the Needle with Personalized Patient Payment Plans

Medical Economics, January 2, 2019
The Benefit of Flexible Patient Payment Options