



Managing Increasing Bad- Debt and the Uninsured

**Presented to:
Institute of Healthcare Executives and
Suppliers**

**The Westin La Cantera Resort
March 15, 2007**

Presentation Agenda

- Historical Trends
- Hospital Performance
- Why this matters
- Case Studies
- Questions

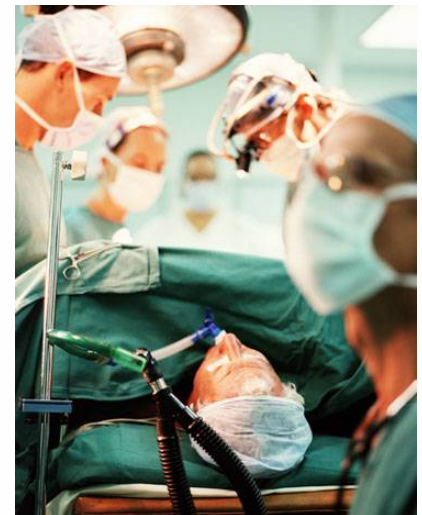


A circular inset image showing a stethoscope and a reflex hammer on a light-colored surface. The stethoscope is positioned in the lower-left quadrant, and the reflex hammer is in the upper-right quadrant. The text "Historical Trends" is overlaid in the center of the circle.

Historical Trends

America's Healthcare Dollar

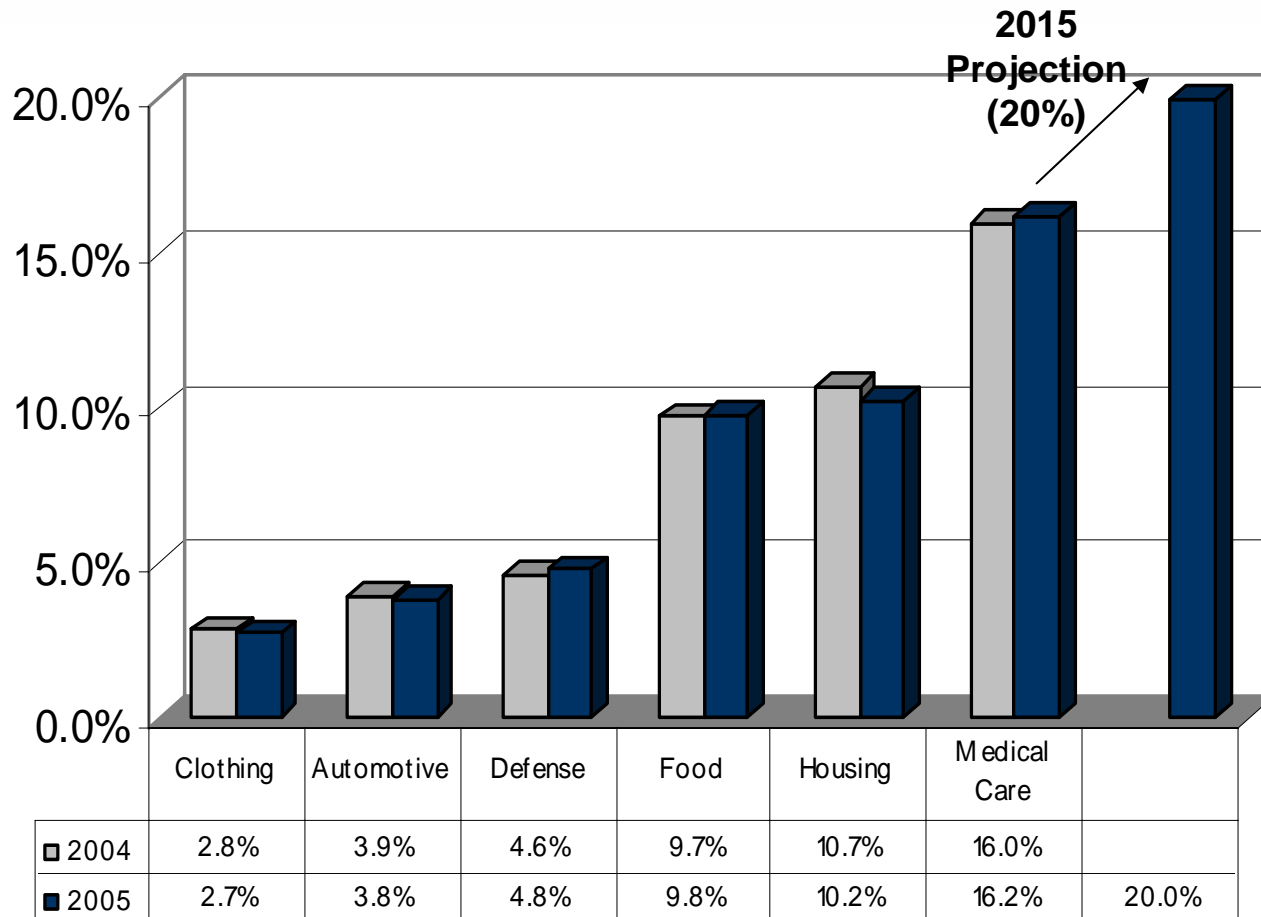
	Sources	Uses	
Private Insurance	35¢	31¢	Hospital Care
Medicare	17¢	21¢	Physician
Medicaid	16¢	10¢	Rx
Out-of-Pocket	13¢	6¢	Home Care
Other*	19¢	7¢	Administration
		25¢	Other**
	\$1.00	\$1.00	



*Workers Comp, VA, Defense Dept., Philanthropy

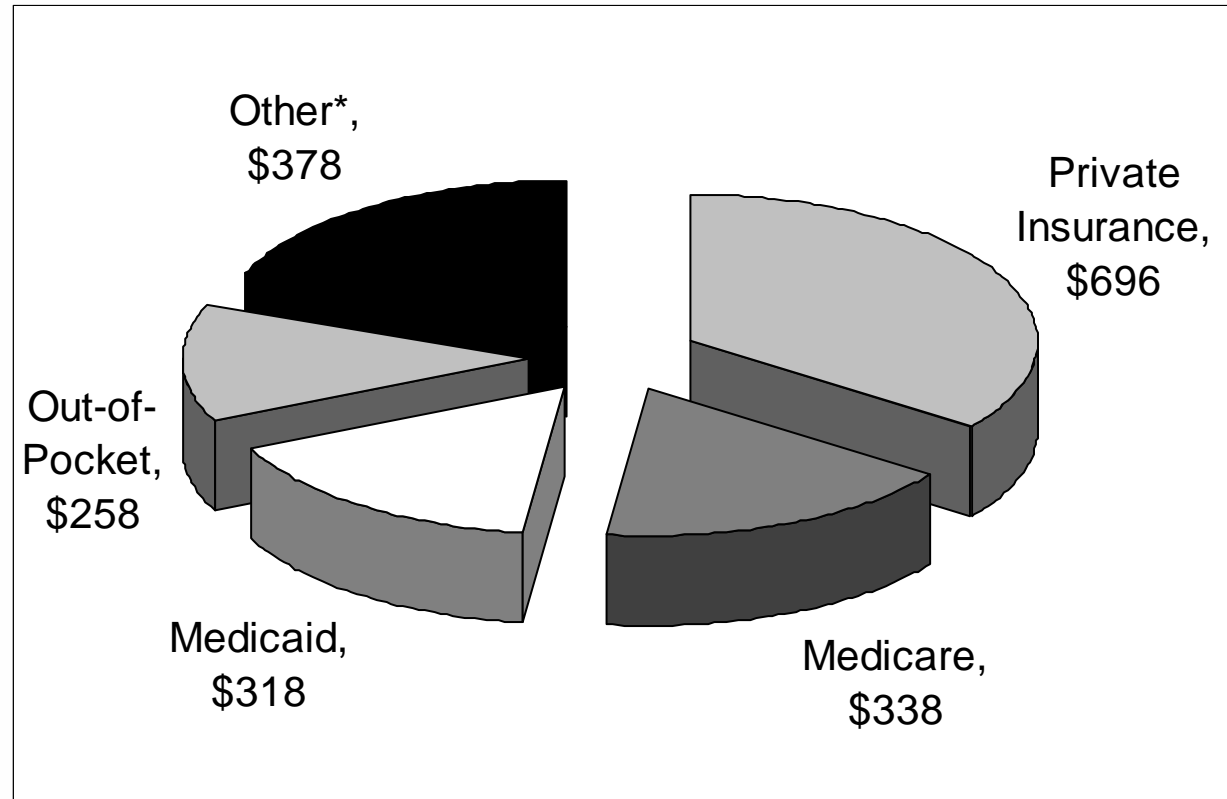
**Dental, DME, Over-the-Counter Medicine, Research, Construction

Selected Components of the GDP



Amount and Sources of Payment for Care

Amount and Sources of Payment for Care – 2005 (\$ billions)...



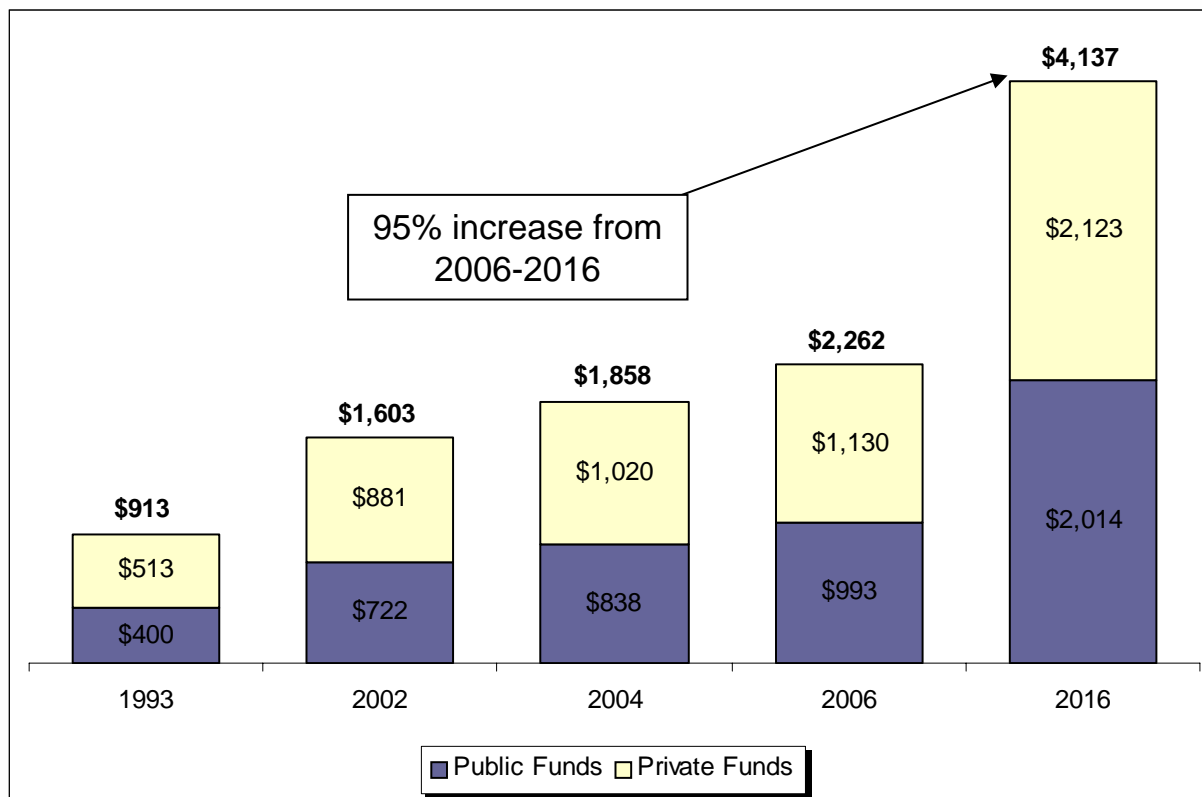
\$440.8 billion by 2016
(71% increase in 10 years)

Source: CMS 2005

Breakdown of National Health Expenditures by Public and Private Funding

National Healthcare Expenditures (\$ billions)

- **95% increase from 2006-2016**
 - 102% increase in public finding
 - 88% increase in private funding)

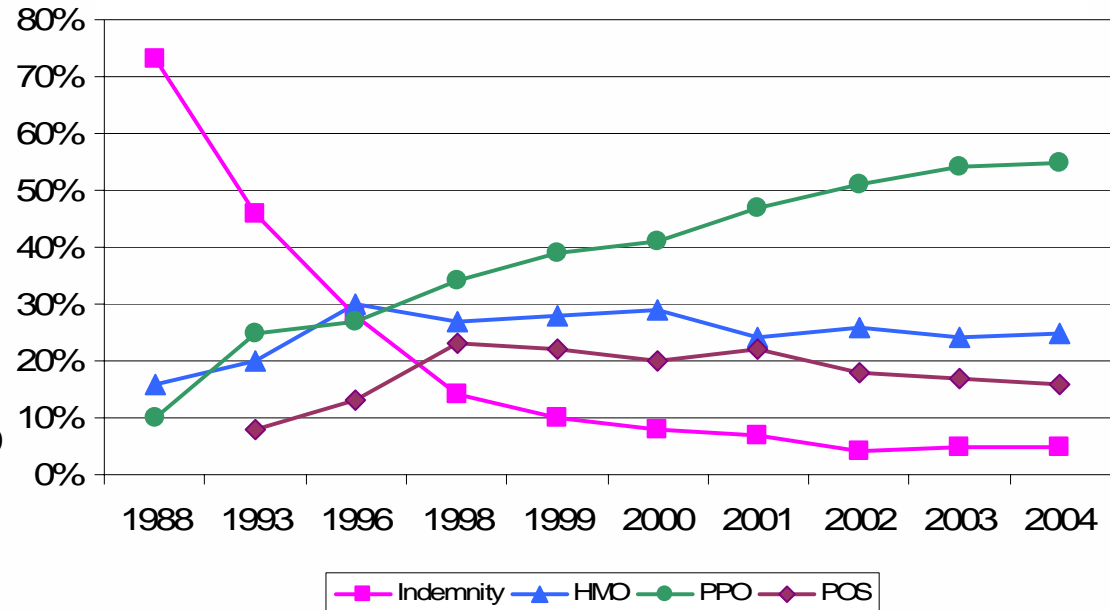


*Projected
Source: Health Affairs January/February 2007

Cost & Reimbursement Payers

- Uncertainty of future managed care model
- Employers shifting more healthcare financial risk to employees
- “Ditto” Uncle Sam
- Coupling reimbursement to quality/safety
- Viewing physicians and hospitals as a “joint provider” of services

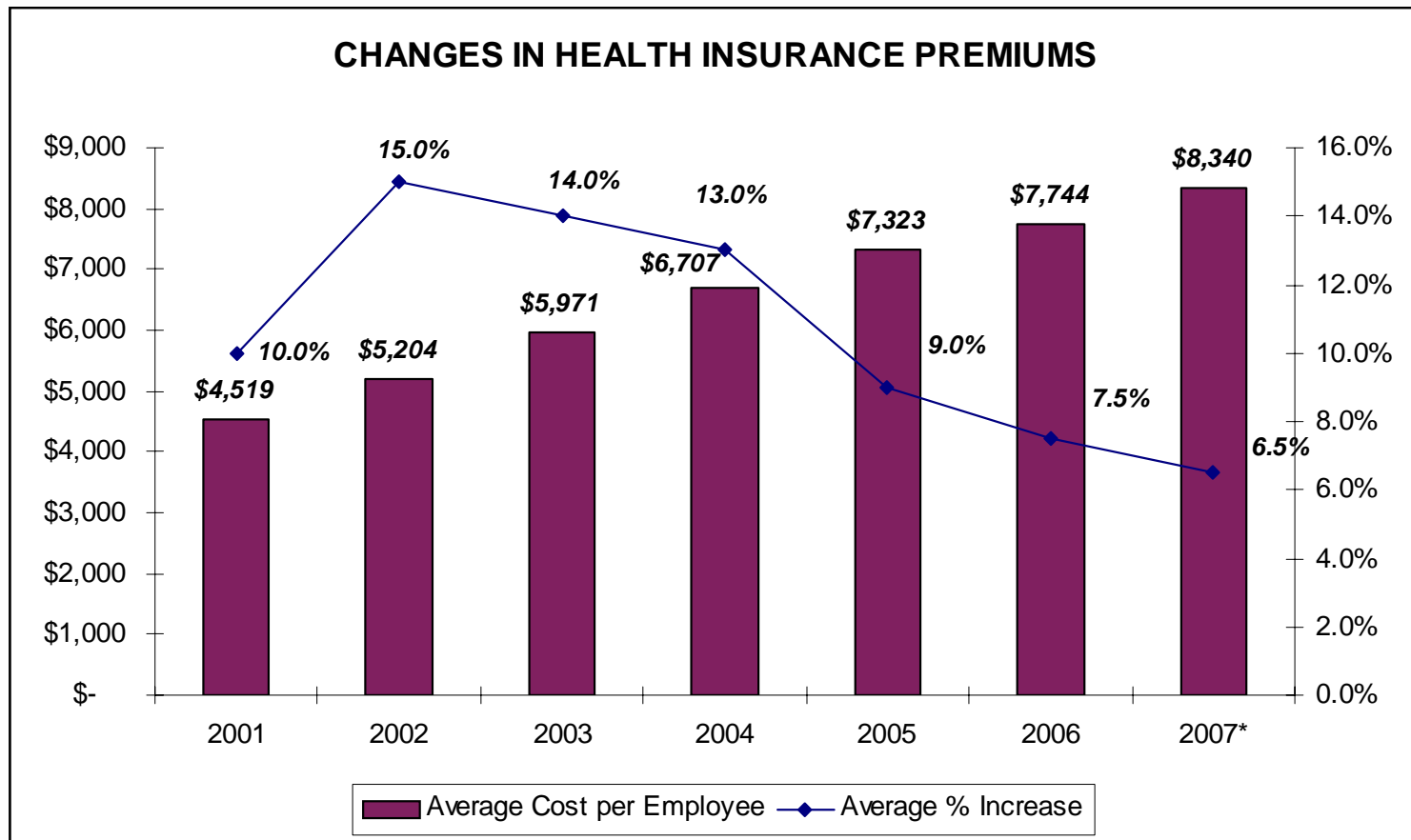
Health Plan Enrollment, by Percentage of Covered Workers



Source: Modern Healthcare, December 20, 2004

Insurers and Managed Care Trends

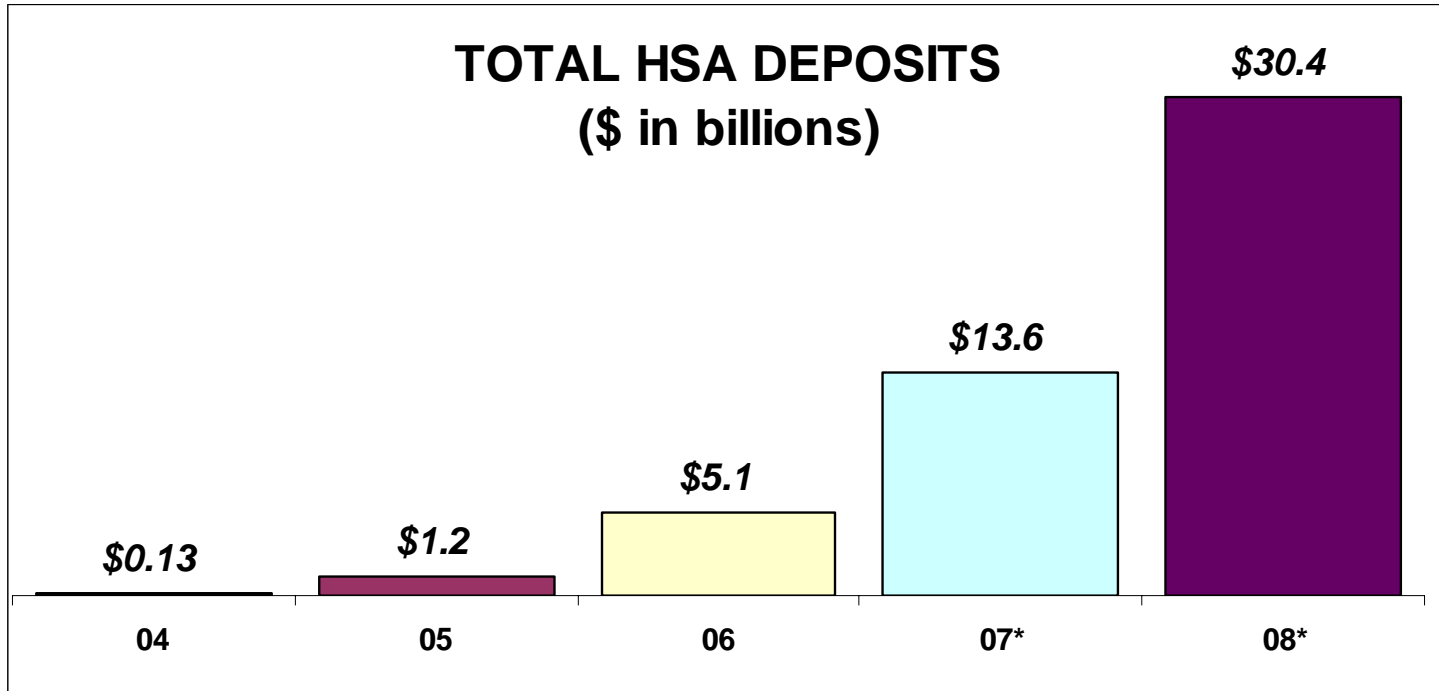
Health insurance premiums continue to rise at a faster rate than medical costs. In most years studied, insurance premiums increased 2% to 5% more than medical costs.



Source: Modern Healthcare
December 2006

Source: Hewitt Associates, 847-295-5000, hewitt.com

Insurers and Managed Care Trends



Who's Enrolling In HSA's?

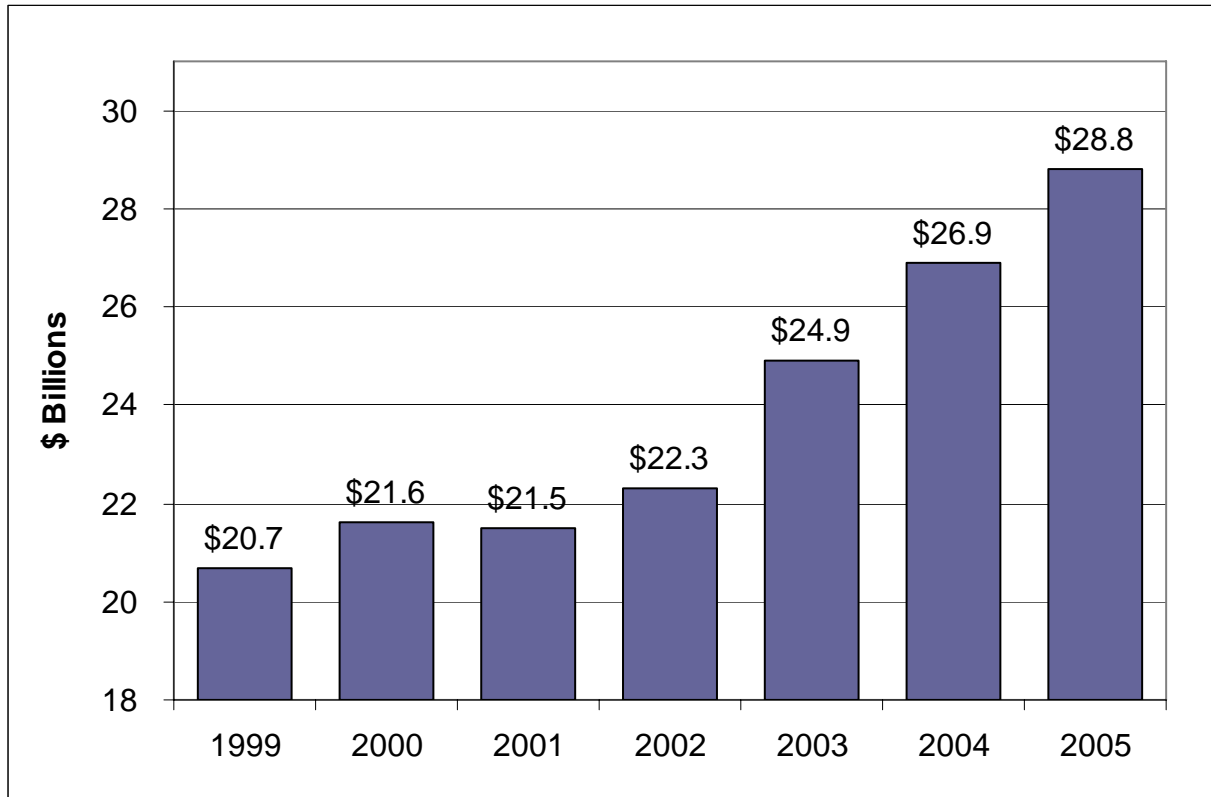
- Average age – 46
- Average income - \$45,000 +
- Gender (male/female) – 55% - 45%
- Advanced education – 62%

Historical Trends

Uncompensated Care (1999 – 2005)

National Uncompensated Care based on cost*

- Uncompensated care increased 39% from 1999-2005



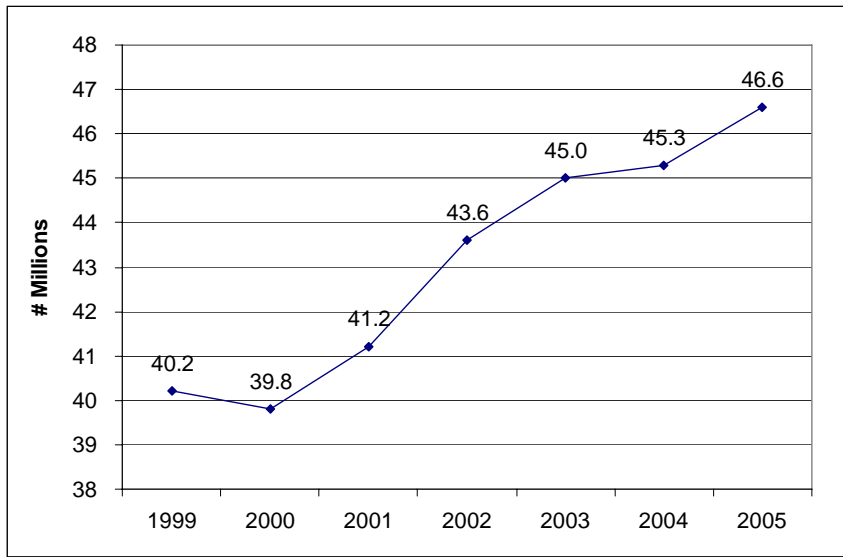
Source: American Hospital Association; Uncompensated Hospital Care Cost Fact Sheet; October, 2006

*Represents the estimated cost of bad debt and charity to the hospital

Historical Trends Uninsured

Uninsured...

- Undocumented workers (est. 9.5 million) increased 23% during the same time period...nearly half (44%) are not US Citizens
- Southern border states have the highest uninsured
 - 25% of Texans are uninsured
- The number of uninsured will increase by about 500,000 per year through 2010. In 2007, 16% of Americans (46.4 million) will be uninsured.



Who are the Uninsured?

<u>Category</u>	<u>% of Uninsured</u>
18-24 years of age	30.6%
25-34 years of age	26.4%
Income less than \$25,000	24.4%
Hispanic	32.7%
Not a US Citizen	43.6%
No work experience	27.3%

Source: U.S. Census Bureau, "Estimates of the Size and Characteristics of the Undocumented Population," Pew Hispanic Center, KaiserStateHealthFacts.org

Factors Contributing to rising uninsured and underinsured rates...

- Narrow profit margins forcing employers to cut benefits
- Double digit increases in premiums forcing employees to drop coverage
- Small businesses are dropping coverage because of cost
- Changes in the economy resulting in lost jobs

Reasons for increases in patient balances...

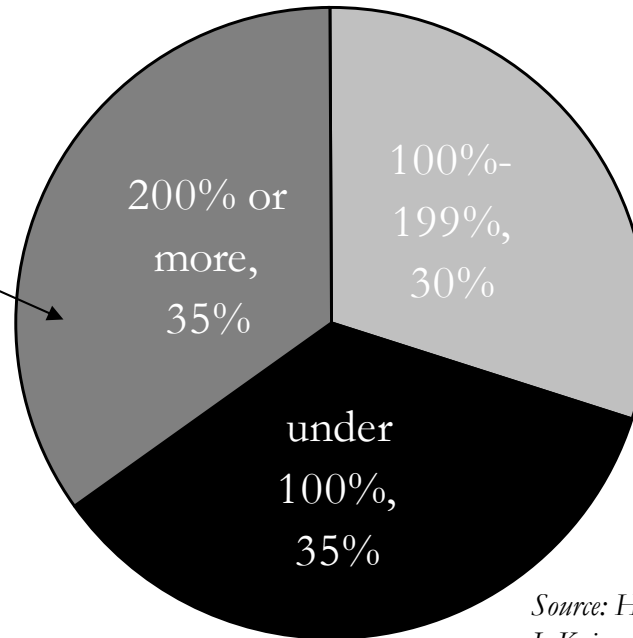
- Cost shifting - higher employer premiums forcing employees to cover more of the cost through deductibles, coinsurance, co-payments

Historical Trends

Non-elderly uninsured by federal poverty level

The uninsured aren't necessarily unemployed...

1/3rd of non-elderly population is over 200% of federal poverty level



Definition:

Uncompensated care is medical care received that is not fully paid for either out-of-pocket from individuals or by a private or public insurance payer.

Source: Henry J. Kaiser Family Foundation

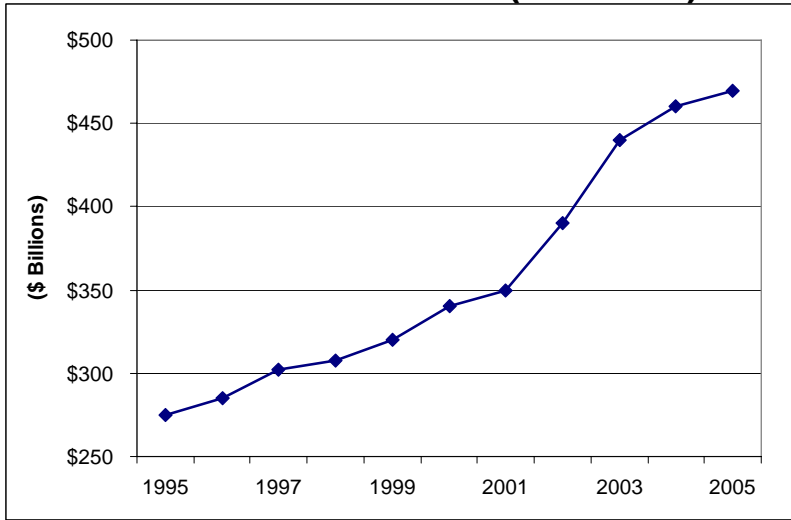
Most of the uninsured (78.8%) were employed or in working families, including one-quarter of Americans in households earning three to four times the federal poverty level (\$55,980 to \$74,640 for a family of four).



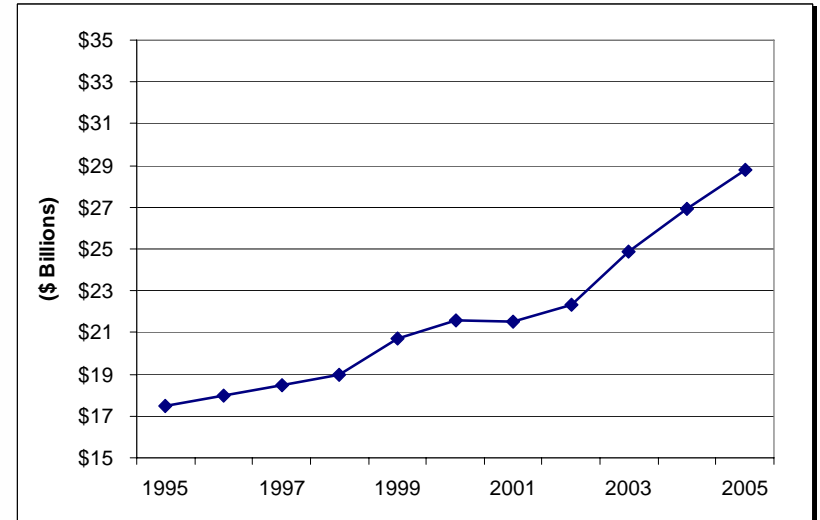
Hospital Performance

Hospital Performance

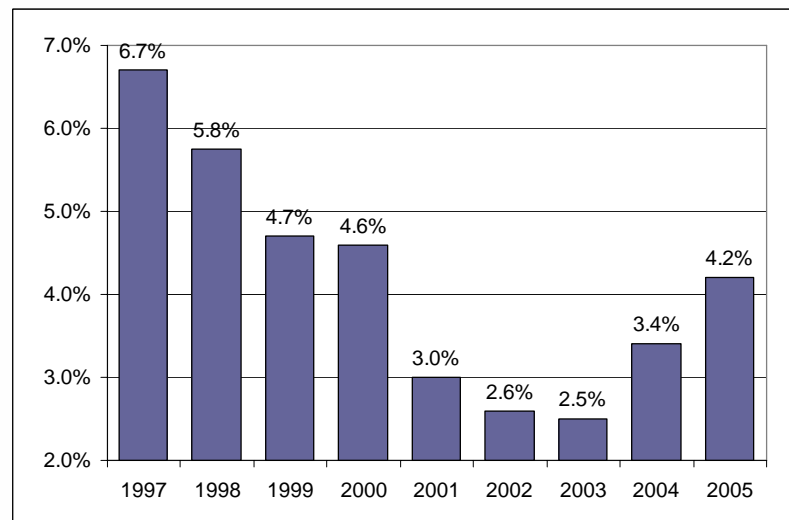
Net Patient Revenue (\$Billions)



Uncompensated Care



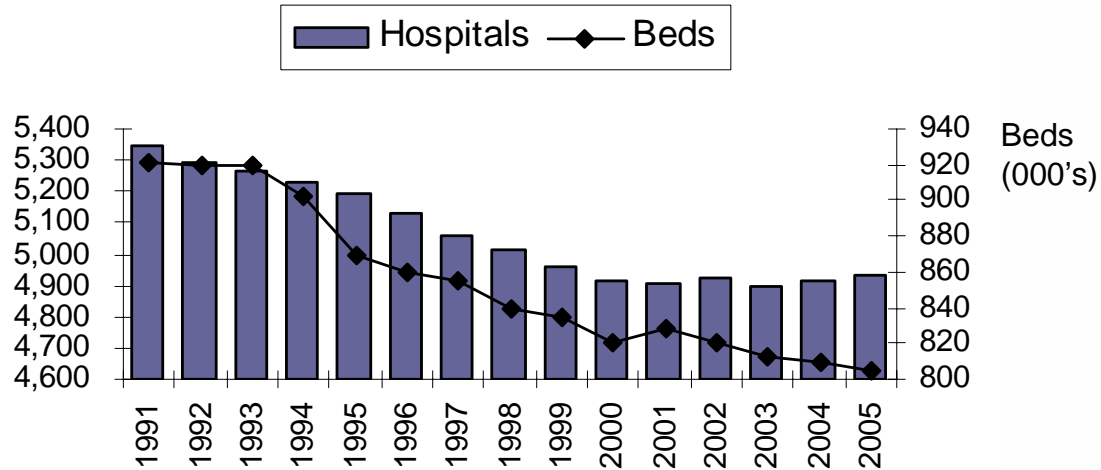
Total Margins for US Hospitals (%)



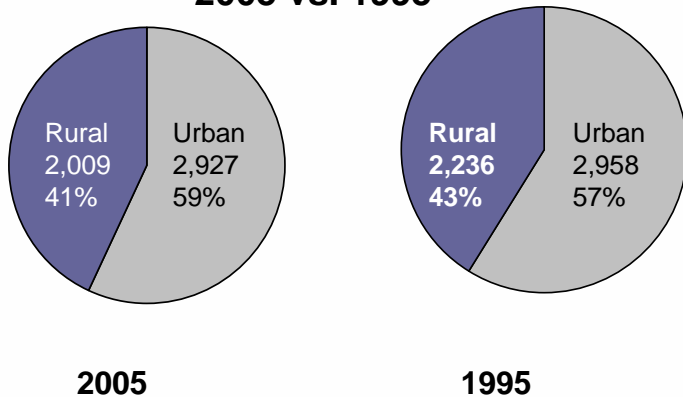
Source: Ingenix 2007 Almanac of Hospital Financial & Operating Indicators

America's Hospitals

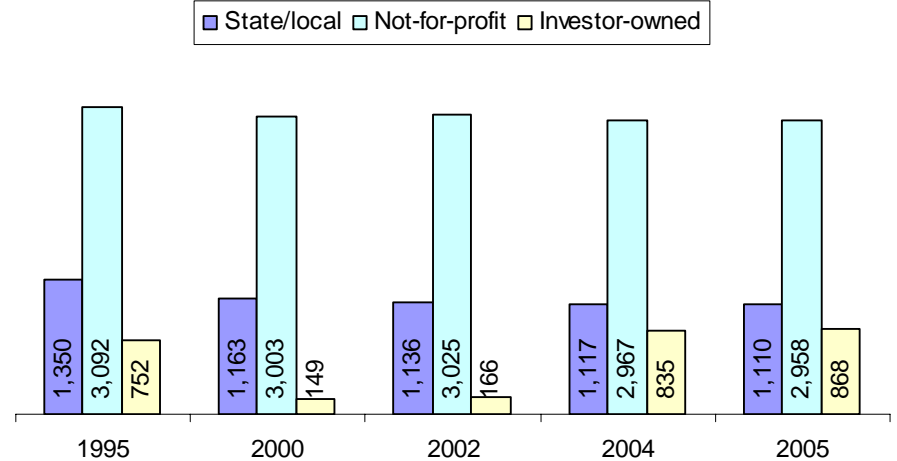
Total Number of Hospital and Beds



Hospitals By Location 2005 vs. 1995

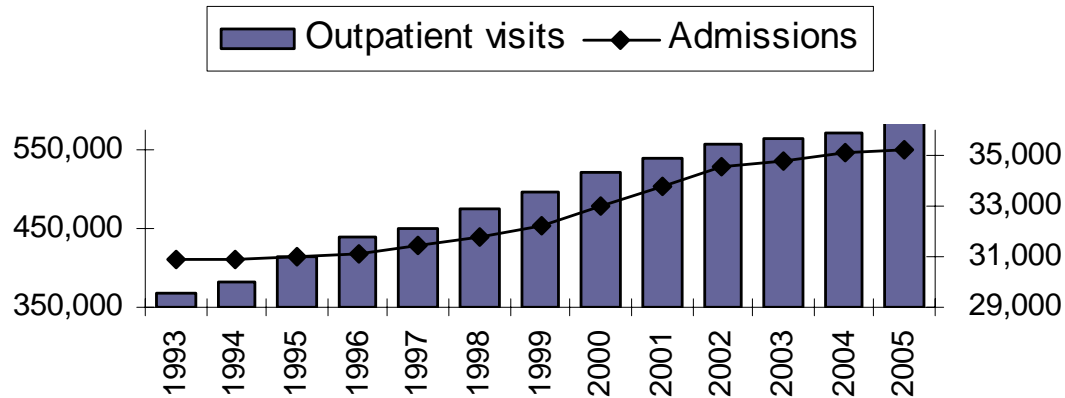


Acute-care Hospitals by Type of



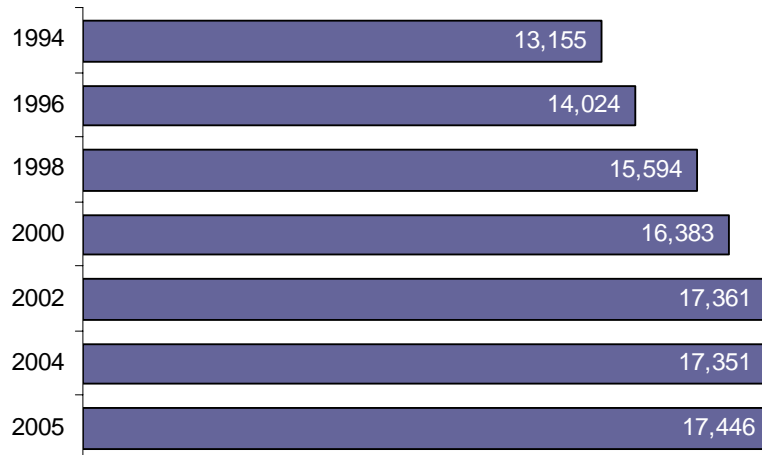
Hospital Statistics

Hospital Admissions and Outpatient Visits (000's)



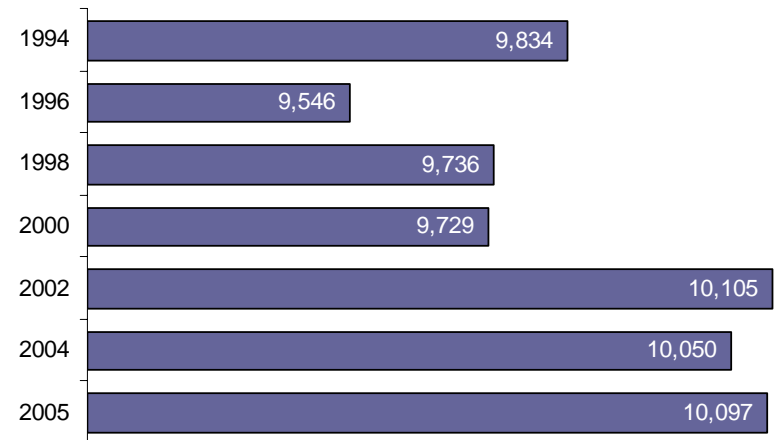
Outpatient Surgeries, 1994-2005

Surgeries (000's)



Inpatient Surgeries, 1994-2005

Surgeries (000's)



A circular inset image showing a stethoscope and a reflex hammer on a light-colored surface. The stethoscope is positioned in the lower-left quadrant, and the reflex hammer is in the upper-right quadrant. The text "Why this Matters" is overlaid in the center of the circle.

Why this Matters

Why this matters

More write-offs...Rising bad debt...Increased denials

Administrative

Missing or incorrect demographics, insurance or did not verify eligibility or obtain pre-certification.

Clinical

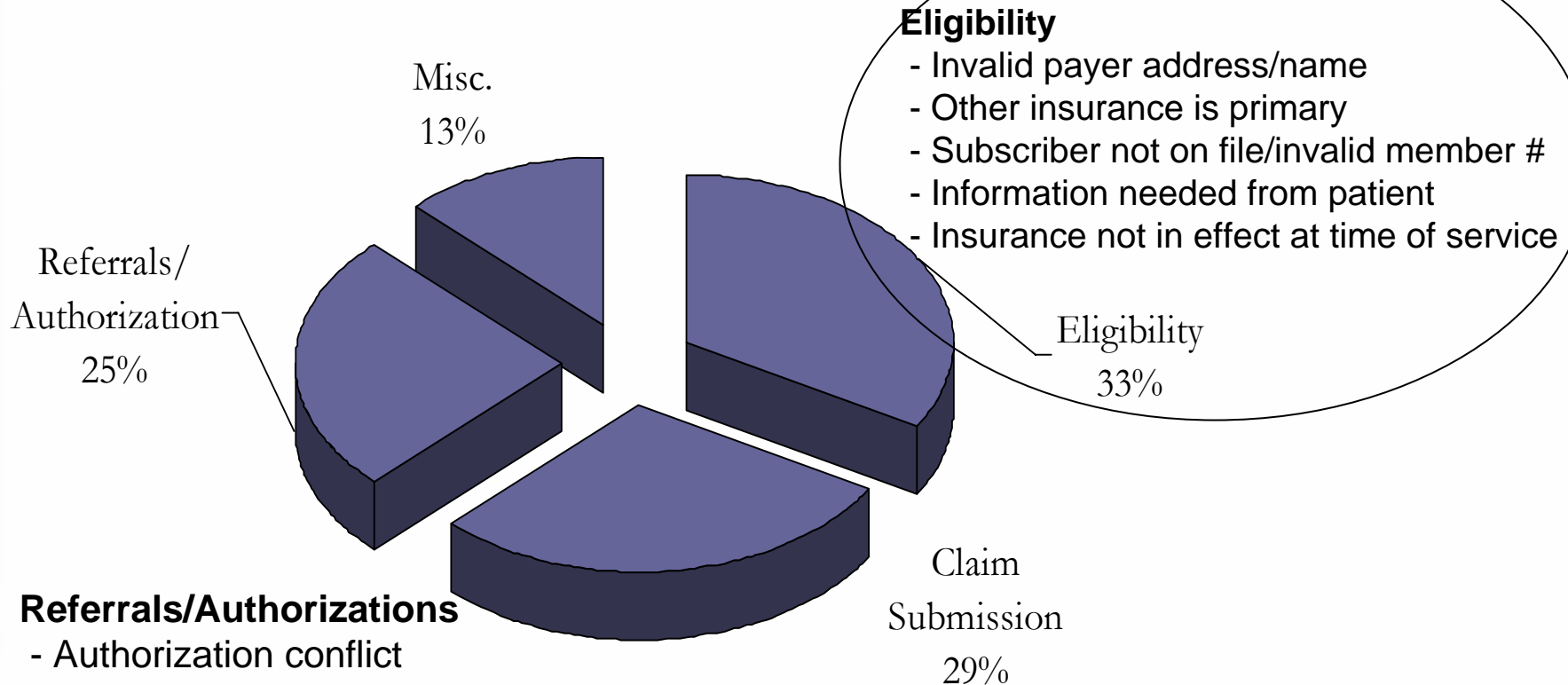
Medical necessity was not demonstrated or proven.

- A denial is a missing check, treat it as such because it is cash missing from the bottom line.
- Denials are either upheld, overturned or a work-in-process
- A successful overturned denial is measured by dollars collected
- There must be accountability in all areas

Understand why denials are occurring

Why this matters

Reasons for Claim Rejections

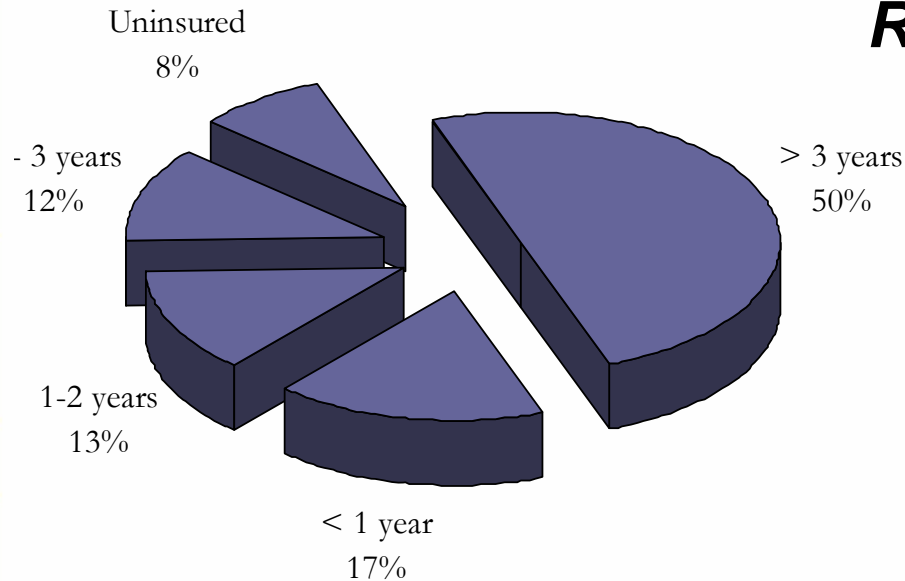


Source: Healthcare Financial Management Association

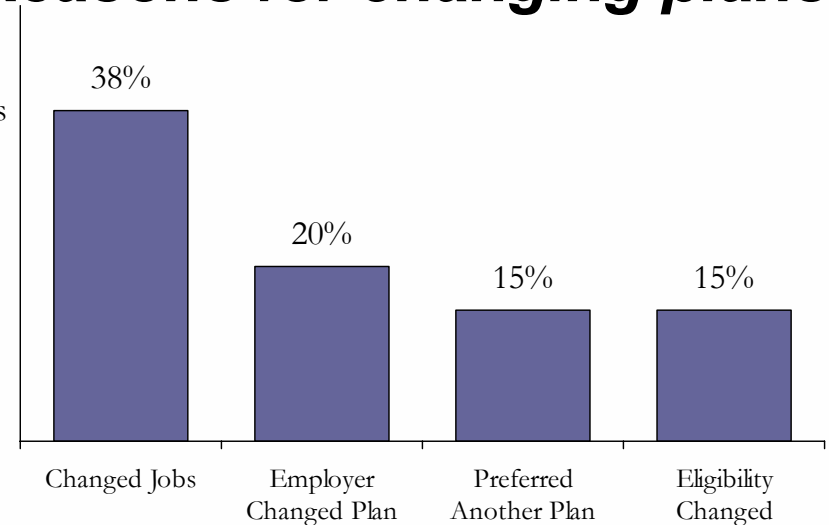
Why this matters

Average time in a Health Plan...

Health plan enrollment can change yearly.
Only 1/2 of the insured stay in a health plan for longer than 3 years.



Reasons for changing plans...

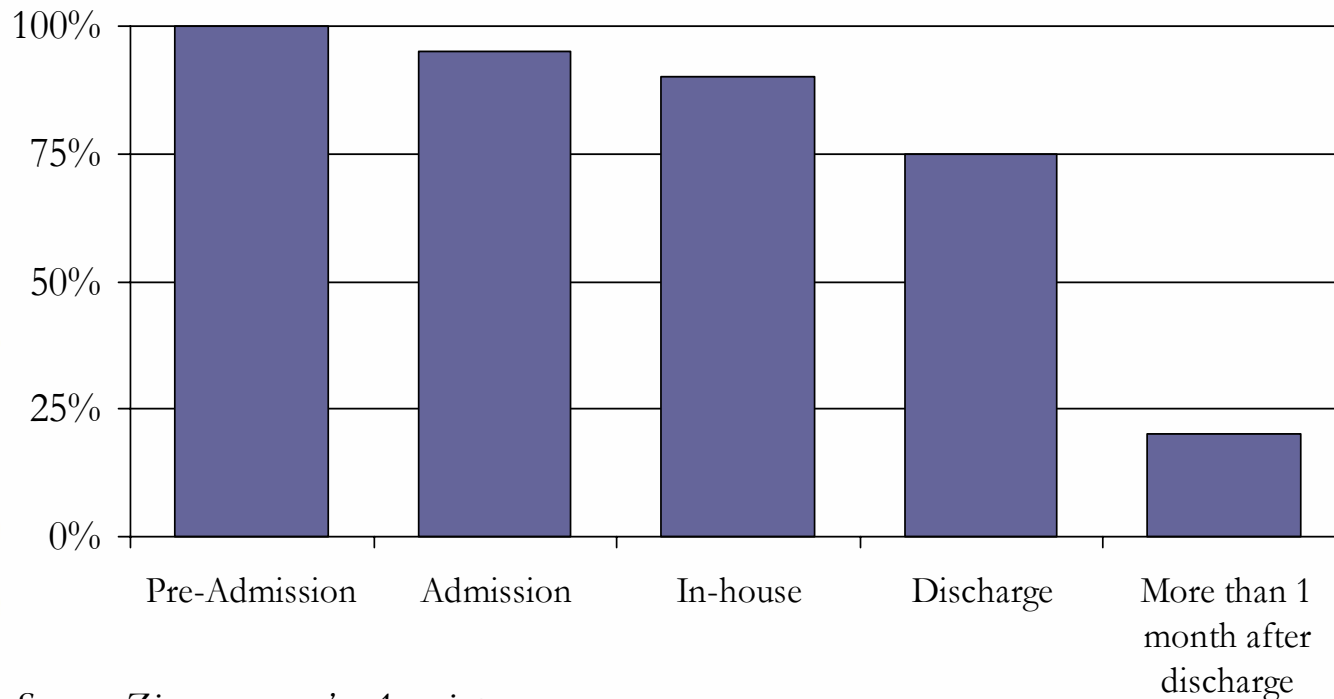


Source: Healthcare Financial Management Association

Why this matters

Collections is a function of time-of-service

Before service, during, and at service you are dealing with a patient. At collection follow-up you are dealing with a debtor. Patient priorities are different than debtor priorities.



Source: Zimmerman & Associates

Obtain Quality Information in the Beginning

Do it once...do it right

Establish a process and focus on front end quality and you will reduce the amount of time spent on re-working write-offs, denials, and/or delayed accounts.

Challenges to Front End Quality

- **Multiple entry points** that have their own idea of data-gathering criteria and often with different software systems.
- No **established process**
- Often **poor communication**
- **Training** - Untrained/Unqualified staff
- Not enough **staff** members
- Etc., Etc,



Uncompensated Care Recommendations

- Improve processes to identify uncompensated care, including large patient responsible balances
- Align charges to the underinsured with discounts similar to other payers
- Simplify the charity care qualification process
- Clearly communicate financial assistance policies to patients
- Fortify the front line - improve training and invest in highly skilled patient access staff
- Establish payment plans and bank-loan programs for large balances
- Assign financial counselors in the ED, to direct admits, and high-dollar outpatient procedures

Right Care – “to the right place at the right time”

Harris County Hospital District – Houston, TX

Lyndon B. Johnson, Ben Taub Hospital

Issue

- More than 50% of the 166,000 ED patients treated last year at the two public facilities did not require emergency care.
- Due to overcrowding in the emergency departments, the two hospitals are frequently forced to divert ambulances carrying critically ill patients to other area facilities
- In 2005, Ben Taub was on “drive-by” status 42% of the time and LBJ diverted ambulances approximately 55% of the time.

Solution

- Require adult patients who arrive at the ED with non-urgent medical needs to instead seek care at community health clinics.
- Patients ages 18 and older seeking care at either of the public hospitals’ EDs are screened by a nurse practitioner or physician’s assistant and referred to a community clinic when appropriate.
- Patients who insist on staying at the hospitals will be required to pay a \$150 up-front deposit for ED care or an \$80 deposit for use of the hospitals’ urgent care centers.
- Patients who agree to be redirected will be paired with a RightCare assistant who will help them locate the most convenient clinic.
- The program will help area residents establish a “medical home” where they can continue to receive primary care.
- The initiative is projected to reduce ED visits by approximately 20% and help curb ED spending

EMTALA State Operations Manual

Part I – Investigative Procedures

I. General Information, page 5 paragraph 6

A hospital must formally determine who is qualified to perform the initial medical screening examinations, i.e., qualified medical person. While it is permissible for a hospital to designate a non-physician practitioner as the qualified medical person, the designated non-physician practitioners must be set forth in a document that is approved by the governing body of the hospital. Those health practitioners designated to perform medical screening examinations are to be identified in the hospital by-laws or in the rules and regulations governing the medical staff following governing body approval. It is not acceptable for the hospital to allow the medical director of the emergency department to make what may be informal personnel appointments that could frequently change.

Case Study: MyVisit Program

Pre-Service Model

Geisinger Health System - A multi-disciplinary group practice of approximately 700 physicians, three hospitals (200+ bed medical center, a large 400+ bed tertiary/quaternary teaching hospital and an alcohol and drug treatment center).

- Gross Days Revenue Outstanding – 28.2 days
- Bad Debt and Charity Care – 1.4% of gross revenue
- Cost to Collect (fully loaded) – 3.1%

The Challenge

- As consumer-driven healthcare and patient satisfaction moves to the forefront of medical care, processes associated with efficient patient flow, wait times and various administrative functions needed to be addressed. Nationally, emphasis is now moving toward consumer-driven healthcare. As consumers become more involved with their selection of healthcare services, we felt it important to also encourage a culture in which patients acknowledge their own accountability (including financial accountability).

Goals

- Separate the clinical encounter from the financial clearance process
- Shift the revenue cycle processes' focus **from post-service and point-of-service to pre-service**
- Provide a foundation for subsequent initiatives such as: patient-friendly billing, the combination of billed services with respect to patient statements across entities, on-line statement review and payment, consumer-driven healthcare, and pricing transparency
- **Program Name** - With an emphasis on patient-centric care, the program was named "MyVisit"

Case Study: MyVisit (Strategy)

1. *Redefine the patient encounter to align with specific functions:*

- *Pre-service (prior to the encounter)*
- *Point-of-service (at the time of encounter)*
- *Post-service (after the encounter)*

2. *Separate administrative processes from the clinical encounter, thus: Increasing clinical caregiver(s) focus (and time) on the clinical encounter*

The MyVisit process completes the following functions in advance of the patient clinical encounter:

- Registration
- Insurance eligibility checking
- Verification of patient insurance benefit levels
- Pre-certification
- Medical necessity checking
- Referral authorizations
- Identification and communication of the patient out-of-pocket obligation (e.g., co-payment and deductibles)
- Financial counseling, including payment plans, discount policies, access to charity care and alternate payment arrangements
- “Special Handling” accounts (package pricing, cosmetics, dialysis, transplant etc.)

Completion of these processes allows for a patient to be “**financially cleared**” before services are rendered. Patients are deemed financially cleared if these conditions have been met and the related processes have been successfully completed:

Case Study: MyVisit (Benefits)

Patient Satisfaction

- The patient encounter is now focused on the clinical experience, thus eliminating or reducing the previously “perceived” focus on financials
- Eliminates the “hassle factor” of having to register multiple times for same day services
- Patient privacy is protected by allowing communication of information from a patient’s home (or other non-public environment)
- Reduction in check-in line wait times decrease patient anxiety and frustration

Operational Benefits

- Physician’s schedules are on time with no delays due to the registration process
- Clinical scheduling and productivity are optimized through reduction in “no-show” rates; scheduling slots are better managed
- Employee satisfaction improves through reduction in administrative tasks and increased time spent on patient needs

Financial Benefits

- Mitigation of overall financial risks by closing the financial clearance gap(s)
- Provides a foundation for introducing proactive patient financial policies
- Manages the organizational risks as payors increase requirements for medical justification for patient services

Return on Investment

- The first nine (9) months of the implementation of MyVisit resulted in the financial clearance of approximately \$420 million in net revenues, resulting in nearly \$6.7 million in losses avoided or increased net revenues. Expenses associated with the MyVisit program during this implementation period were \$2.8 million.

What to do?



Panel Questions

1. What trends are occurring in your area and your facility regarding uncompensated care and bad-debt?
2. How are providers in your area addressing these trends?
3. Does your organization offer discounts to the uninsured and under-insured for services? Do other providers in your market offer discounts?
4. In order to minimize write-offs and denials, some facilities require financial clearance (medical necessity, insurance verification, or charity/Medicaid application) prior to services being rendered. Without such clearance, non-emergent services are rescheduled until clearance is obtained. Are these extreme measures or supportable for long-term sustainability?
5. Some emergency departments redirect low acuity patients to lower cost alternatives and require payment from uninsured after screening but prior to treatment? Is this supported by providers in your market? What other solutions exist?
6. What strategies and tactics have proven useful and successful to your facility in minimizing write-offs and managing uncompensated care?

A Demotivational Thought



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Discussion



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