Are Your Patients Now Your Payers? New Tools for Your Lab to Collect More Money, Faster, and at Less Cost

2019 Executive War College

Walt Williams
Director, Revenue Cycle Optimization & Strategy

Quadax, Inc.
My Background

✓ 26 year laboratory veteran

✓ Leader of Revenue Cycle and Market Access teams:
  • Genoptix, Genzyme Genetics, Impath, Unilab

✓ Architected and operationalized numerous reimbursement models:
  • Fee-for-Service, Case Rate / Episode of Care, Capitation, Panel
Over 45 Years of Experience

By the Numbers

- 365,000+ Providers
- 4,000+ Payers
- 50 States Processing Claims
- 165M+ EDI Transactions
- $32B Provider Payments
- 52% Acute Care Claims
- 225+ Hospitals/Health Systems
- 95%+ Client Retention
- 42 States With Existing Clients
Our People

6
Office locations

2,500+
Annual on-site visits

800+
Total employees

10+ Years Experience
30% of employees have 10+ years experience in revenue cycle/medical billing

70+
Client services support team members dedicated to supporting our Partnership and SaaS solutions

100+
IT/Application development employees
Key Learning Objectives:

✅ Market Trends & Forces that are shaping future Patient Access strategy
  • Patient out-of-pocket
  • Patient consumerism evolution
  • Payer policies

✅ Explore new Patient Access tools available to Labs and other HCP’s that address these market challenges
  • Service overview
  • Best practices
  • Key considerations for implementation
Market Trends & Forces
(aka patients are more like Amazon shoppers)
It’s time to understand the importance of patient financial education.

68%
Prefer to know financial obligations at, or before, discharge

Over 1/3
Want to know financial obligations prior to admission or registration

74% of insured consumers
Indicated they are both willing and able to pay out-of-pocket medical expenses up to $1,000 per year (90% up to $500/yr.)

52% of Consumers
Would pay from $200 to $500 if an estimate was provide at the point of care.

Source: IMA Consulting
50% of denials are due to avoidable pre-service errors.

Source: Latest Trends in Hospital Revenue Cycle Performance, Advisory Board Financial Leadership Council, 2017
Patient Access 2.0 – Future State

- Patient Scheduled & Test Considered
- Patient Access Inquiry (Portal or API)
- Coverage Verification & Validation

- Patient "Propensity to Pay" determined
- Patient Out-Of-Pocket Estimated
- Payer Policies Identified (Coverage, PA)
### Rising Deductibles = Patient Financial Engagement

![Graph showing average annual health plan deductibles for single coverage, 2006-2017.](https://www.kff.org/report-section/ehbs-2017-section-7-employee-cost-sharing/attachment/figure%207_10-11/)

<table>
<thead>
<tr>
<th>Year</th>
<th>Deductible</th>
<th>With &amp; W/O Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>$584</td>
<td>$303</td>
</tr>
<tr>
<td>2016</td>
<td>$1,505</td>
<td>$1,221</td>
</tr>
<tr>
<td>Increase</td>
<td>158%</td>
<td>120%</td>
</tr>
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</table>

Evolution of the Patient Consumer

When searching for a new doctor or medical professional, consumers are most concerned with convenience, cost, and reputation.

Survey question: When you are searching for a new doctor or medical professional, which of the following do you consider most important?

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>In network for my health insurance</td>
<td>50%</td>
<td>46%</td>
</tr>
<tr>
<td>Convenient location</td>
<td>46%</td>
<td></td>
</tr>
<tr>
<td>Reputation</td>
<td>39%</td>
<td></td>
</tr>
<tr>
<td>Personality/bedside manner</td>
<td>34%</td>
<td></td>
</tr>
</tbody>
</table>

Other responses:

- 32% Convenient hours and accessibility
- 16% Medical school/training of the physician
- 31% Price I have to pay/my out-of-pocket expenses
- 10% High quality ratings from a magazine or ranking website
- 27% Affiliation with my local hospitals
- 8% Use of technology for other services, such as getting test/lab results
- 25% A friend or family member's recommendation
- 5% Use of technology for scheduling and payment
- 20% High user reviews from other patients
- 4% Offers telemedicine/virtual visits

Patient consumers open to new care pathways

At-home self-diagnostic and genetic tests are becoming more popular among consumers. Many consumers are comfortable using at-home tests for their current health concerns and identifying potential future health issues. For instance:

- **Fifty-one** percent are comfortable using an at-home test to diagnose infections (such as strep throat and urinary tract infection) before going to the doctor for treatment.
- **Forty-five** percent are comfortable using an at-home genetic test to identify existing or future health risks.
- **Forty-four** percent are comfortable using an at-home blood test that connects to an app to track overall health trends.
- **Forty-one** percent are comfortable sending/mailing a stool sample to a laboratory service that identifies gut bacteria, which in turn can help guide nutritional choices.

Patients demanding pricing transparency

Complete Blood Count (CBC) with Differential

Fair Price $23

$17 - $141+

CASH PRICE DISCOUNTS

Bluebook has identified the following providers who offer significant savings for patients who pay cash prior to the procedure. Read More...

Distance: All

Price: [Link2Labs (mail)]

Call

Disclaimer: You must pay for your procedure prior to receiving care. Cash price is not applicable if you have Medicare or Medicaid. Read More...

Complete Blood Count - CBC Test

Cost Overview

National Average: $14 - $33
California State Average: $15 - $38
Los Angeles, CA Average: $13 - $36

How Are These Numbers Calculated?

The cost information on Guroo is estimated and is based on over 750 million claims from a set of insurers and their reported negotiated rates with providers. These estimates are trended to and considered valid through July 1, 2018 based upon claims paid between July 1, 2014 and June 30, 2016.

Do not avoid getting health care based on the information on this site.
In Summary

✅ Higher **deductibles** are influencing patient consumerism behavior
  - > $2K deductible from only 5% of insured to 25% ( +400%)
  - < $500 deductible from over 58% of insured to only 12% ( -380%)

✅ Multiple inputs being considered by patients
  - Key drivers include **Network Status** (50%), **Service Cost** (31%) and ** Ease of Payment** (5%)

✅ Patients more willing to use **online tools** to find high quality, lower cost providers
  - 22% increase in usage over the last 3 years
Patient Access Solutions Unpacked
Patient Access Solutions

- **Insurance Eligibility**
  - Avoid Processing Errors and Denials
  - Eliminate Reworks

- **Insurance Discovery**
  - Identify Additional Coverage from Third-Party Payers

- **Identity Verification & Demographic Repair**
  - Improve Registration Accuracy & Collections

- **Out-of-Pocket Estimation**
  - Increase Payment Transparency

- **Deductible Monitoring**
  - Collect from third-party
  - Patient outreach when time is right

- **Healthcare Policy Discovery & Navigation**
  - Prior Authorization
  - Medical Necessity

- **Patient Financial Clearance**
  - Patient’s Propensity to Pay
## Expanded Patient Access Tool-Set

<table>
<thead>
<tr>
<th>Patient Access Service</th>
<th>Legacy (1.0)</th>
<th>Expanded (2.0)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligibility</strong></td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td>Insurance Discovery</td>
<td></td>
<td>✅</td>
</tr>
<tr>
<td>Deductible Monitoring</td>
<td>✅</td>
<td></td>
</tr>
<tr>
<td><strong>Identity Verification &amp; Repair</strong></td>
<td></td>
<td>✅</td>
</tr>
<tr>
<td><strong>Out-Of-Pocket Estimation (OOPE)</strong></td>
<td></td>
<td>✅</td>
</tr>
<tr>
<td><strong>Payer Policy Discovery &amp; Navigation</strong></td>
<td></td>
<td>✅</td>
</tr>
<tr>
<td><strong>Financial Clearance / Propensity to Pay</strong></td>
<td></td>
<td>✅</td>
</tr>
</tbody>
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Advanced Eligibility Verification

**Best Practice:**

Verify the patients insurance eligibility coverage and benefits early (and often) to determine:
- Patient responsibility
- Meet payer requirements
- Reduce claims denials

- Initiate Eligibility Verification for every encounter via integration with your patient education portal, test ordering portal, Lab Information Management System, or Revenue Cycle system
- Drill down to insurance plan / product level to improve claim success
- Rules-based and automated deductible monitoring
Identity Verification and Repair

*Best Practice:*

Improve registration accuracy by verifying patient identity and demographic information BEFORE

- Submitting claim or
- Patient statement.

- Services exist that can verify patient demographic registration data against comprehensive databases covering 500 + million people
- Reduce claim denials and undeliverable patient statements
- Reduce manual work – increase customer satisfaction (reduced calls for information)
Demographic Repair – Proof of Concept Results

PoC File
10K records

Advanced Eligibility

Insurance Validations

75%

7% Lift

Rejections

Confirmed

Insurance Discovery

Demographic Verification

Manual Intervention

Systematic Updates

82%
8,224

7% Improvement over basic eligibility resulting in less manual work (724 records)

Fewer call-backs to referring physician asking for updated information
Best Practice:
Increase pricing transparency by providing accurate estimation of patient liability amounts

Caution: This is VERY hard to do well

- Payer + provider contract status (in or out of network) + payer medical policies most accurate method
- Have a policy for how you communicate deductible amounts – Point in time estimation
- Auto-identify potential additional procedures to further enhance true OOPE for patients
Preauthorization Assessment

**Best Practice:**

- Confirm prior authorization requirements prior to service to lower odds of denial
- Consider specimen process and hold rules until PA requirements are met or patient has agreed to pay.
- Consider use of third party for Physician-Initiated Prior Authorizations.

☑️ Check every encounter via integration with your patient education portal, test ordering portal, Lab Information Management System, or Revenue Cycle system
☑️ CPT + Payer rules engine
☑️ Preauthorization Assessment process is integrated with overall solution workflow
Payer Medical Necessity

**Best Practice:**

- Identify potential coverage issues **prior** to claim submission and provide a more accurate OOPE
- Automate medical necessity verification & ABN generation process.
- Ensure ABN’s provide patient financial responsibility.

✔ Check every encounter via integration with your **patient** education portal, **test** ordering portal, Lab Information Management System, or **Revenue** Cycle system
✔ Payer + CPT + ICD-10 + other policy specific inputs must be captured
✔ Cases are flagged if Procedure-Diagnosis combination fail any NCD/LCD edit
✔ ABN form, if required, auto prepared for patient signature
Propensity to Pay and Community-Based Financial Aid

**Best Practice:**

**Improve self-pay collections through**

- The accurate classification of accounts into the optimal payment workflow
- Consider patient’s unique financial situation.

- Target your scarce collection resources carefully – refer more difficult cases to third party
- Ensure payment policies correctly applied to every patient
- Create payment decision messages to guide staff assist staff to engage patients in accordance with organization’s collection policies
- Maximize pre-service and point of service collections
Maximize Patient Collections

**Essential Technology**
- Exception Based Workflow
- Automated Insurance Verification
- Accurate Pre-Service Estimation
- Streamlined Prior-Authorization
- Targeted Propensity to Pay

**Patient Collections Best Practices**
- Monitor collection results vs. goals
- Prepare the patient for financial responsibility
- Ask for patient payments that reflect patient’s ability to pay
- Identify mutually agreeable payment terms
- With “right” payment amount confidently ask for payment
Robust Patient Access Benefits Summary

By conquering patient access issues, you will:

- Optimize patient collections
- Reduce denials with accurate information
- Reduce back-end costs
- Increase transparency, enhancing the patient experience
- Drive automation of the revenue cycle
Thank You!
Questions?

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