HEALTHCARE ADMINISTRATIVE TECHNOLOGY ASSOCIATION (HATA)

MEMBERSHIP MEETING

SCHAUMBURG, IL

TUESDAY, NOVEMBER 13, 2018

FIRST ORDER OF BUSINESS

- Call to Order/Welcome – **Eric Christ**, President of HATA
- Welcome & Participant Introductions- **Tammy Banks**, Vice President of HATA

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HEALTHCARE ADMINISTRATIVE TECHNOLOGY ASSOCIATION

HATA Report:

PMS Industry Landscape – Expansion/ Consolidation

Eric Christ, President of HATA

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NCVHS Predictability Roadmap

Tammy Banks, Vice President
Gary Beatty, Optum [X12 Chair]
Moderator: Betty Gomez, Co-Chair HATA Roadmap Workgroup

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National Committee on Vital and Health Statistics

Advising the HHS Secretary on National Health Information Policy

Draft Recommendations for the Predictability Roadmap

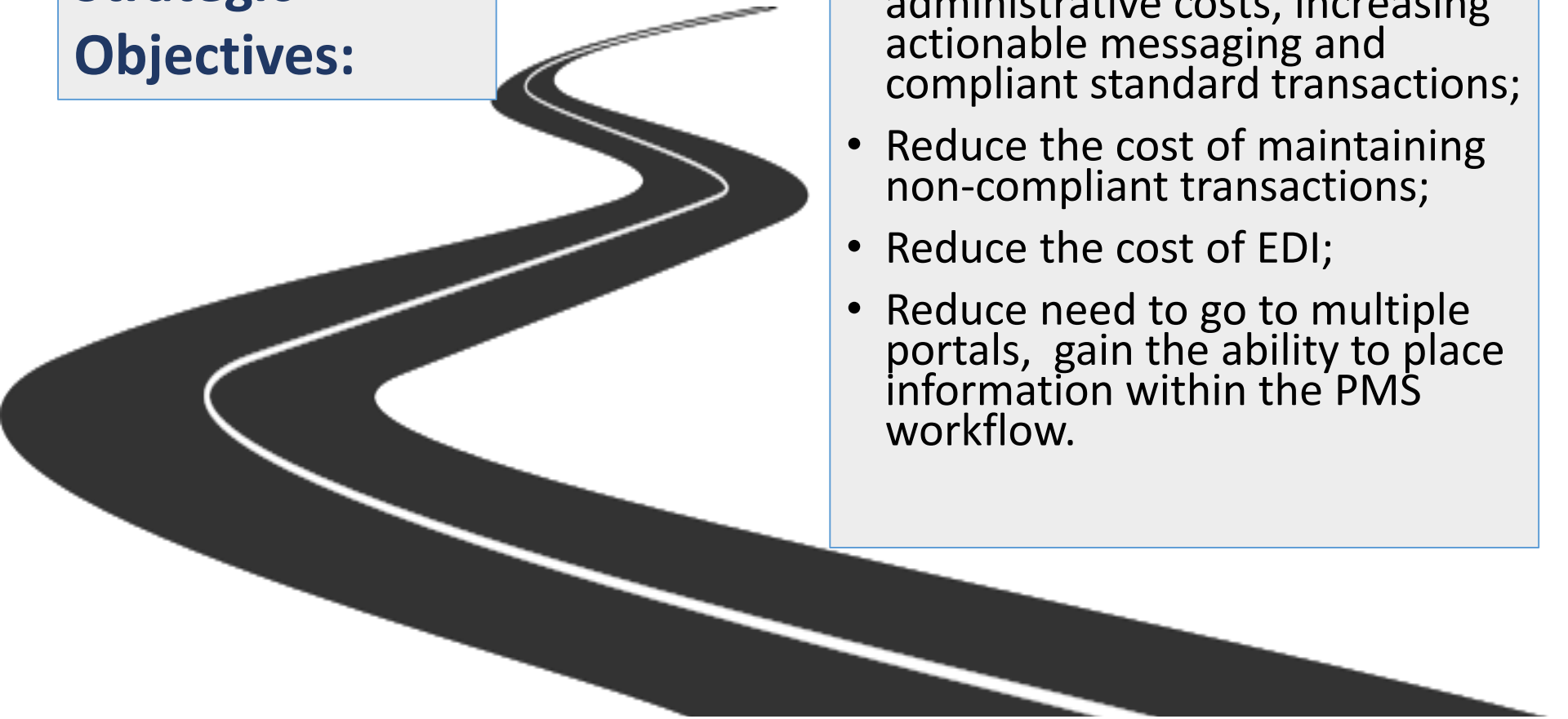
October 2018

AGENDA

I. HATA Industry Roadmap Response to initial NCVHS Predictability Roadmap
II. NCVHS Predictability Roadmap History & Recommendations
III. The PMS Voice

Healthcare Administrative Technology Association Industry Roadmap

Strategic Objectives:



- Increase adoption of EDI;
- Reduce unnecessary administrative costs, increasing actionable messaging and compliant standard transactions;
- Reduce the cost of maintaining non-compliant transactions;
- Reduce the cost of EDI;
- Reduce need to go to multiple portals, gain the ability to place information within the PMS workflow.

Six Topic Areas

- Streamlined, automated, meaningful information exchange.
- Information exchange that meets identified business needs of all stakeholders.
- Validate business needs and positive ROI prior to the recommendation of any standard or operating rule.
- Interoperability principles for meaningful information exchange.
- Expansion of ONC API transparency requirements to administrative use cases.
- Convergence of the administrative and clinical data to meet business use cases.

The NCVHS Predictability Roadmap

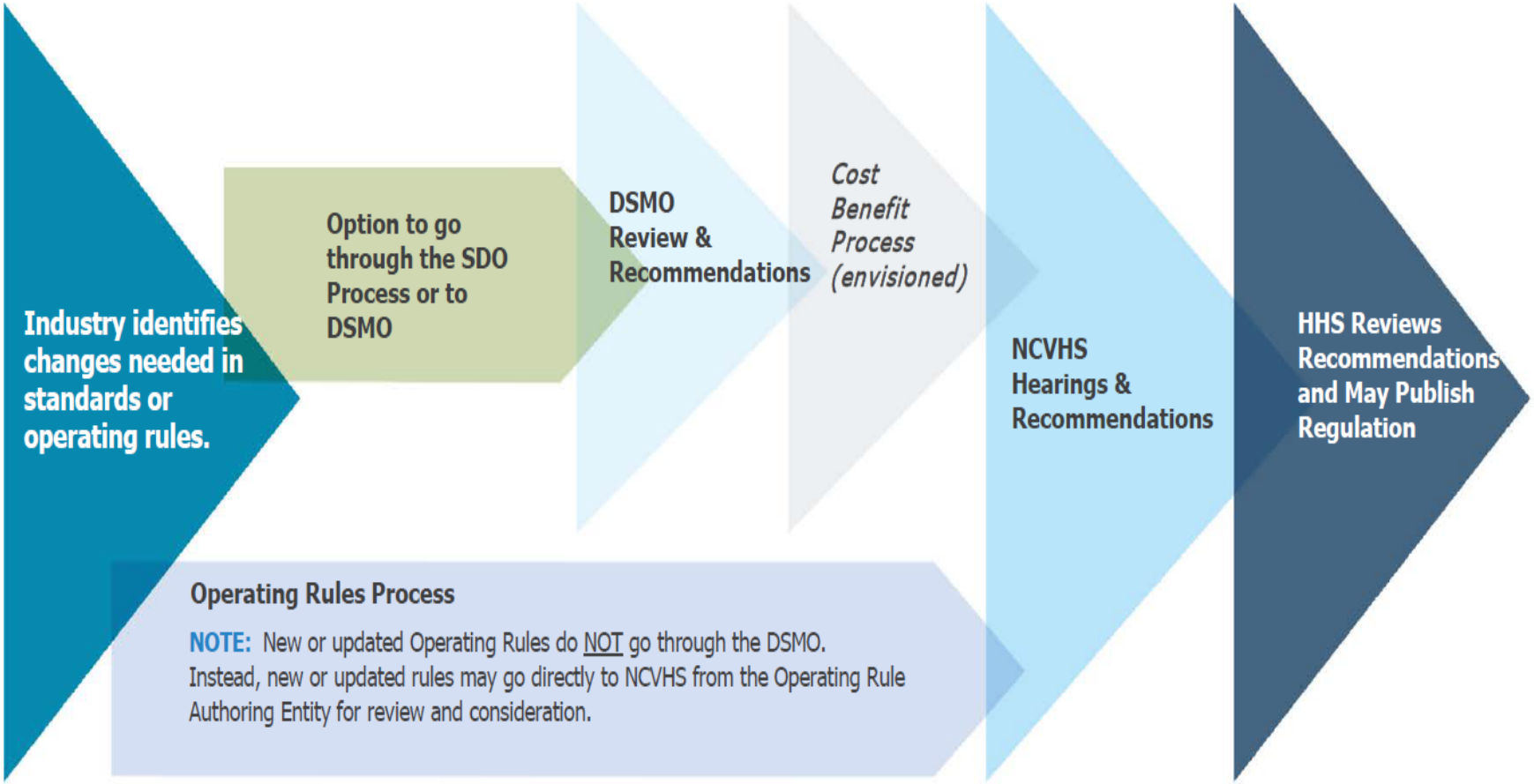
- Standards development, adoption and implementation are not predictable and are not keeping pace with business and technology innovations.
- The Predictability Roadmap is an initiative to evaluate barriers to the update, adoption and implementation of standards and operating rules under the authorities of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Patient Protection and Affordable Care Act of 2010 (ACA).
- For the past 18 months, NCVHS has been collaborating with industry stakeholders to understand the challenges and develop actionable recommendations for the Secretary of HHS, covered entities, standards development organizations and operating rule authoring entities.

Vision

For covered entities and business associates to be able to use up-to-date HIPAA standards consistently, garnering increased value from the standards by avoiding "one-off" work arounds, and to reliably know when updated versions will be updated and adopted in time to prepare systems, resources and business processes.

Standards Update Process - Overview

Current Process for Receiving Recommendations for Updates to Standards and Operating Rules



Development

Throughout 2017 – Information gathering efforts with:

Standards Development Organizations (or SDOs):

- ASC X12 (X12)
- CAQH's Committee on Operating Rules (CORE)
- Health Level Seven (HL7)
- National Council for Prescription Drug Programs (NCPDP)
- NACHA – The Electronic Payments Association (NACHA)

Regulators and governance entities:

- Designated Standards Maintenance Organization (DSMO)
- HHS/CMS/Division of National Standards (DNS)

August 2017 – An initial Visioning Workshop identified five core themes:

1. Governance,
2. Updates to standards,
3. Regulatory processes,
4. Data harmonization*, and
5. Third parties as covered entities.

** The theme of data harmonization will be addressed in the Subcommittee's Terminology & Vocabulary (T&V) project.*

Development, continued

May 2018 – CIO Forum held with industry experts and end users from a variety of health care organizations yielded cross cutting themes of transparency, measurement and collaboration.

July 2018 – The Subcommittee compiled their findings into three (3) outcome goals with a set of draft recommendations, calls to action and measurement.

Recognizing the effort to make proposed changes, the outcome goals are broken into two year sprints.

October 2018 – Outreach to stakeholders throughout the fall (Oct/Nov) leading to a hearing in December to obtain feedback on draft recommendations.

Emphasis of the Draft Recommendations

- Improvements for the federal processes
  - More visible enforcement of existing regulations
  - More frequent guidance and outreach to industry
  - Improve responsiveness to NCVHS recommendations and timeliness of regulatory activities
- Improvements for SDO processes
  - Increase diversity of industry participation in standards and operating rule workgroups
  - Improve timeliness of standards development to support innovation and evolving business and technology changes
  - Improve workgroup processes for productivity
- Governance and Oversight (*Stewardship*)
  - Transparency of processes (Federal and SDO)
  - Advancing industry needs and garnering value from standards

Roadmap Outcome Goals

1. Improved education, outreach and enforcement* will promote efficient planning and use of the adopted HIPAA standards and operating rules.
   This goal supports the themes of Regulatory Processes and Third Parties as Covered Entities.

2. Policy levers will successfully support industry process improvement changes.
   This goal supports the themes of Governance and Updates to Standards.

3. Regulatory levers will enable timely adoption, testing and implementation of updated or new standards and operating rules.
   This goal supports Updates to Standards and Regulatory processes.

*Enforcement includes complaints and compliance reviews/audits

Draft Recommendations (1)

	2019 – 2020 Improved education, outreach and enforcement* will promote efficient planning and use of the adopted HIPAA standards and operating rules.	2020 – 2021 Policy levers will successfully support industry process improvement changes.	2021 – 2024 Regulatory levers will enable timely adoption, testing and implementation of updated or new standards and operating rules.
Recommendations	**1.** HHS should increase transparency of their complaint driven enforcement program by publicizing (de-identified) information on a regular basis. HHS should use all appropriate means available to share (de-identified) information about complaints to educate industry. **2.** HHS should comply with the statutory requirements for handling complaints against non-compliant covered entities and process enforcement actions against those entities and their business associates. Information should be publicized about the status of complaints to the extent permitted by the law. *enforcement includes complaints, audits and compliance reviews as defined in statutory language.	**3.** HHS should disband the Designated Standards Maintenance Organization (DSMO) and work with its current members for an organized transition. **4.** HHS should enable the creation of an entity tasked with oversight and governance (stewardship) of the standards development processes, including the evaluation of new HIPAA standards and operating rules. HHS should provide financial and/or operational support to the new entity to ensure its ability to conduct effective intra-industry collaboration, outreach, evaluation, cost benefit analysis and reporting. Oversight criteria would take into account ANSI Essential Requirements for any ANSI accredited organization; these would also provide consistency to governance of all standards and operating rule entities. **5.** HHS should conduct appropriate rulemaking activities to give authority to a new governing body (replacing the DSMO) to review and approve maintenance and modifications to adopted (or proposed) standards.	**6.** SDOs and ORAE should publish incremental updates to their standards and operating rules to make them available for recommendation to NCVHS on a schedule that is not greater than 2 years. Publication of a new or updated standard is intended to mean the cycle of preparation that meets ANSI requirements (if applicable) for maintaining or modifying a standard or operating rule, including the consensus process, necessary governance compliance and readiness for submission to NCHVS. NCVHS should align its calendar to the SDO/ORAE updates to review and deliver its recommendations to HHS within 6 months. HHS should adopt the NCVHS recommendations on a regular schedule.

Draft Recommendations (2)

	2019 – 2020 Improved education, outreach and enforcement* will promote efficient planning and use of the adopted HIPAA standards and operating rules.	2020 – 2021 Policy levers will successfully support industry process improvement changes.	2021 – 2024 Regulatory levers will enable timely adoption, testing and implementation of updated or new standards and operating rules.
Recommendations	**7.** HHS should regularly publish and make available guidance regarding the appropriate and correct use of the standards and operating rules.	**8.** HHS should publish regulations within one (1) year of a recommendation being received and accepted by the Secretary for a new or updated standard or operating rule (in accordance with what is permitted in §1174 of the Act). **9.** HHS should ensure that the operating division responsible for education, enforcement and the regulatory processes is appropriately resourced within the Department.	**10.** HHS should adopt incremental updates to standards and operating rules. In accordance with Sec 1174 of the Act, the adoption of modifications is permitted annually, if a recommendation is made by NCHVS, and if updates are available. **11.** HHS should publish rulemaking to enable the adoption of a floor (baseline) of standards and operating rules. This rulemaking should also consider other opportunities that advance predictability and support innovation. **12.** HHS should enable voluntary use of new or updated standards prior to their adoption through the rule making process. Testing new standards to enable their voluntary use may be explored by testing alternatives under §162.940 Exceptions from standards to permit testing of proposed modifications. The purpose of this recommendation is to enable innovation.

Draft Calls to Action (1)

	2019 - 2020 Improved education, outreach and enforcement* will promote efficient planning and use of the adopted HIPAA standards and operating rules.	2020 - 2021 Policy levers will successfully support industry process improvement changes.	2021 - 2024 Regulatory levers will enable timely testing, adoption and implementation of updated or new standards and operating rules
Calls to Action	**A.** Health plans and vendors should identify and incorporate best practices for mitigating barriers to the effective use of the transactions, determining which issues are the most critical and prioritizing use cases. **B.** The Workgroup for Electronic Data Interchange (WEDI), through its work group structure, should continue to identify issues and solutions. WEDI should publish white papers advising on agreed upon policy implications and best practices related to use of HIPAA standards and operating rules.	**C.** HHS and the SDOs should identify and fund a best of class third party compliance certification/validation tool recognized and approved by each standards development organization to assist in both defining and assessing compliance. HHS should develop and test criteria for certification, and build a program to enable multiple 3rd parties to qualify to conduct the validation testing by demonstrating their business value. To implement this recommendation, HHS should look at successful precedents such as how the ONC certification criteria was developed for Promoting Interoperability and the eRx requirements which were a joint effort between HHS, NIST and the SDO.	**D.** HHS should fund a cost benefit analysis of HIPAA standards and operating rules to demonstrate their Return on Investment. HHS may consider collaborating with or supporting any existing industry initiatives pertaining to such cost benefit studies to increase data contribution by covered entities and trading partners.

Draft Calls to Action (2)

	2019 – 2020 Improved education, outreach and enforcement* will promote efficient planning and use of the adopted HIPAA standards and operating rules.	2020 – 2021 Policy levers will successfully support industry process improvement changes.	2021 – 2024 Regulatory levers will enable timely adoption, testing and implementation of updated or new standards and operating rules.
Calls to Action	**E.** SDOs should consider collaboration with the private sector to plan and develop outreach campaigns, with the intent to increase the diversity of participants in standards development workgroups. **F.** Leadership from the public and private sector should commit to membership in Standards Development Organizations, assign appropriate subject matter experts to participate in the development and update process, and facilitate improvements to operations as needed. This may enhance diversity of representation in the SDOs so that content changes meet a cross section of stakeholder needs.	**G.** Public and private sector stakeholders should collaborate to design a single coordinated governance process. Governance should include detailed and enforceable policies regarding business practices, including policies for identifying and implementing best practices in such an organization.	**H.** HHS should continue to publish a universal dictionary of clinical, administrative and financial standards that are or will be available for use, e.g. the ONC Interoperability Standards Advisory (ISA).

Recommendations for Measurement

	2019 – 2020 Improved education, outreach and enforcement* will promote efficient planning and use of the adopted HIPAA standards and operating rules.	2020 – 2021 Policy levers will successfully support industry process improvement changes	2021 – 2024 Regulatory levers will enable timely adoption, testing and implementation of updated or new standards and operating rules
Measurement	**M1.** HHS should publicly and regularly disseminate results of its enforcement program to promote transparency, opportunities for education, and benchmarking.	**M2.** HHS and stakeholders participating in the new governance process should establish metrics for monitoring and performance assessment of the new entity, and oversight/enforcement of SDO and ORAE deliverables and performance. **M3.** NCVHS should continue to conduct its stakeholder hearings to assess progress of the Predictability Roadmap.	

Anticipated Timeline/Next steps

Nov 14: HATA Roadmap Workgroup - Vet Draft Testimony
Nov 28: HATA Roadmap Workgroup - Vet Draft Testimony
Nov 28: Finalize Draft Testimony and Submit for Board Review & Approval
TBD : HATA Membership Meeting
Dec 12: HATA submits written comments
Brad Gnagy testifies on behalf of HATA/Tammy Banks testifies on behalf of Optum 360

Dec-Jan: NCVHS incorporates feedback from stakeholders

February 6 & 7: NCVHS conducts Full Committee Meeting

1st Quarter 2019: NCVHS releases letter to HHS based on review and vote on final recommendations

NCVHS Proposed Questions To Consider

1. Would these recommendations as a whole improve the predictability of the adoption of administrative standards and operating rules?
2. What additional recommendations are critical to achieve predictability?
3. What is the value proposition of each recommendation/gı of similar recommendations.

Proactive Claims Handling- Increasing Payer- Provider Actionable Communication

Steve Morelli, United Healthcare
Steve Sewell, Optum 360

Moderator: Tammy Banks, Optum 360

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Streamlining the Eligibility Process-
5010 & 7030 X12 270/271

Donna Campbell, Health Care Services Corporation (HCSC) [X12 270/271 Co-chair]

Moderator: Doug Siber, Board Member of HATA

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7030 TR3 Changes for the 270/271 Eligibility & Benefit Inquiry and Response

What's changing?

7030 270/271

- What's been removed?
- What are the heavy hitting changes?
  - What requirements or new functionality have been added?
- What's Donna's interpretation of the changes, and which do Donna think are the most complex?
- What's the status of the Public Comment Period?

7030 270/271

- Implementing changes today vs. tomorrow
  - What's an easy lift?
  - What can't be done now and has to wait?

- What level of effort from a "payer perspective" (including a thorough analysis of changes, the development and testing of those changes) do we think would be needed to do these changes?
  - What's a best guess ROI?

- What other questions are there?

Pilot/Solution Opportunities

Payer EDI Attachment Opportunity

Mary Lynn Bushman, National Government Services Inc.

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NGS High Level Overview of Electronic Attachment Program

November 13, 2018

National Government Services

About National Government Services (NGS)

NGS is a Medicare Administrative Contractor supporting the J6 and JK Jurisdictions.

We support both **Medicare Part A and Part B** for the following **10** states: Wisconsin, Illinois, Minnesota, Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, New York and Connecticut.

Jurisdiction 6 - Part A and Part B

Jurisdiction K - Part A and Part B

National Government Services

About National Government Services (NGS)

In addition, NGS supports the **Home Health and Hospice** for the following **24** states and territories:
Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Michigan, Minnesota, Nevada, New Jersey, New York, Northern Mariana Islands, Oregon, Puerto Rico, US Virgin Islands, Wisconsin, Washington, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont.

Jurisdiction 6 - Home Health and Hospice

Jurisdiction K - Home Health and Hospice

National Government Services

Why NGS Early Adoption of Attachments

- Key driver for success is satisfied providers
- Reduce provider administrative burden
- Need to build trust to create collaborative partnership
- Provider participation
- Reduce pended claims, denials and appeals
- Reduce phone calls

Future Benefits

- Structured data allows for more efficient processing

National Government Services

NGS Electronic Attachment Workflow

- Processing the X12 275 with the embedded HL7 standard since February 2014
- Enrolled 46 provider organizations for the X12 275 transaction
- Implemented the X12 275 version 6020 with the embedded HL7 CDA R2 or C-CDA R2.1
- Support the Operative Notes and Unstructured document C-CDA R2.1 templates
- Support unstructured file types: PDF, TXT
- Format X12 275/HL7 into an XML file

NGS Electronic Attachment Workflow

- Authentication and Authorization same as all EDI transactions
- Generate the 999 Acknowledgement
- Implemented the X12 277 Health Care Claim Request for Additional Information version 6020
- Support EDI enrollment and set up for the Attachment process
- NGS Companion Guides are available

NGS Attachment Program Successes

Processing the X12 275 version 6020 transaction

Processing the embedded HL7 standard, both unstructured and structured data

Processing both unsolicited and solicited electronic attachments

Successfully receiving and processing electronic attachments for 4½ years

Receiving and processing X12 275 files daily

Enrolled 45 providers Organizations X12 275 transaction

National Government Services

NGS Attachment Program Successes

Electronic Attachments reduce payer costs and reduce provider administrative burden

Providers are able to leverage their existing connections with the NGS EDI gateway

New trading partners simply use the existing electronic attachments process

Electronic Attachments improve provider payment cycles

National Government Services

NGS Stakeholders – Synergistic Business Needs

Early Adopters - Value of Collaborative Partnerships
Sharing synergistic business needs

- The foundation of the program is built on collaborative industry partnership to be able to leverage existing stakeholder IT investments, connectivity and resources to facilitate attachment workflow automation and interoperability
- NGS Industry Collaborative Partners:
- NGS collaborative stakeholder participation includes representatives from the providers, clearinghouses, IT vendors and practice management systems communities, and 46 provider plus organizations including Jopari Solutions, Waystar, eSolutions, EPIC, Athenahealth and Mayo Clinic.

NGS Collaborative EDI Partners Contact Information

EDI Partners	Contact	EMail	Phone#	Website
Athenahealth	Emidio Depina	edepina@athenahealth.com	(617)402-1492	www.Athenahealth.com
Epic	Assigned Technical Service Representative		(608)271-9000	www.epic.com
eSolutions Inc.	Brigitte Rehak	info@esolutionsinc.com	(866)633-4726	www.esolutionsinc.com
Jopari Solutions Inc.	Monica Donato	info@jopari.com	800-630-3060	www.jopari.com
Waystar	Waystar Payer Services	David.Meier@waystar.com	(844)4WAYSTAR (844-492-9782) ext. 9231	www.waystar.com

National Government Services

Questions & Answers

National Government Services

Pilot/Solution Opportunities

Solving for Interoperability: X12 Innovative Messaging Pilot Opportunity

Gary Beatty, Optum [X12 Chair]

Moderator: Tammy Banks, Vice President of HATA

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Smart Attach – Making Attachments Work Within The PMS

Sergiu Rata, S Director Smart Trading, Edifecs

Moderator: Betty Lengyel-Gomez, Chair
Membership Committee

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Streamlining the Contract Administration Process- Addressing Gaps

Patrick Drewry, Advisory Group

Moderator: Doug Seiber, Board Member of HATA

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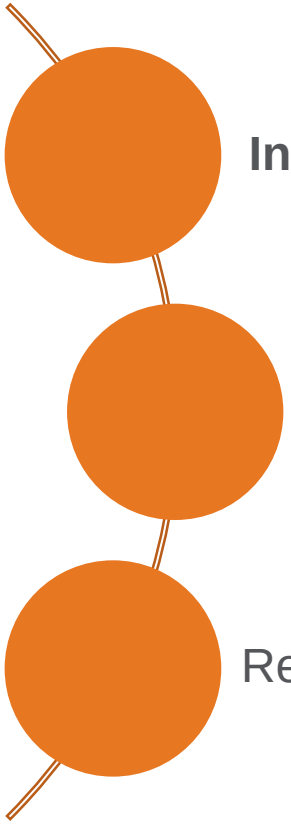
Streamlining Contract Administration

HATA National Meeting

November 12, 2018

OPTUM 360°

Agenda

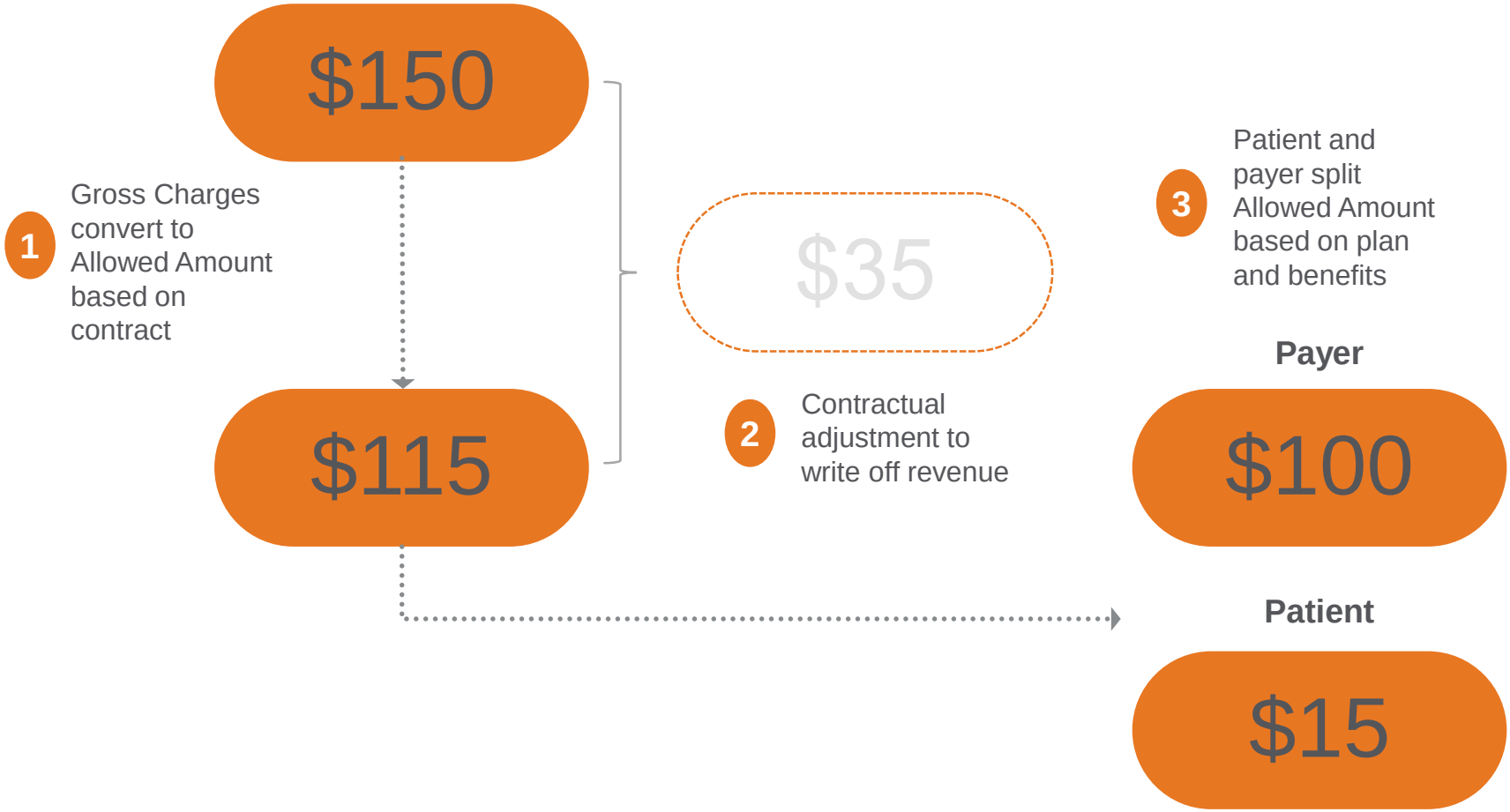


Introduction to contract management

Contract management in ambulatory setting (professional)

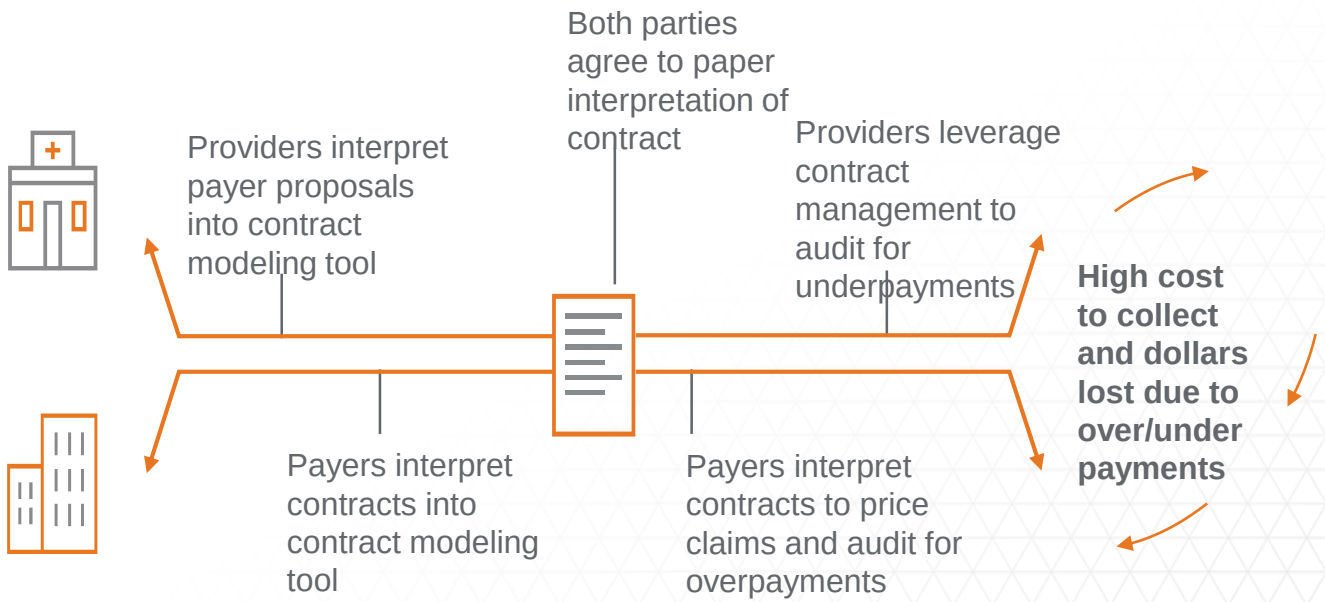
Recommendations

Before we dive in…



Contract Administration is a Nightmare

Contract Agreement and Administration Today



Payment discrepancies due to tremendous manual effort

Contract management value drivers

What if a provider organization could …

CALCULATE

Calculate expected reimbursement based on the claim submitted to the payer and an independent interpretation of the contractual payment terms

RECOVER

Proactively reconcile expected with actual payment to determine payment validity and **recover** payment defects

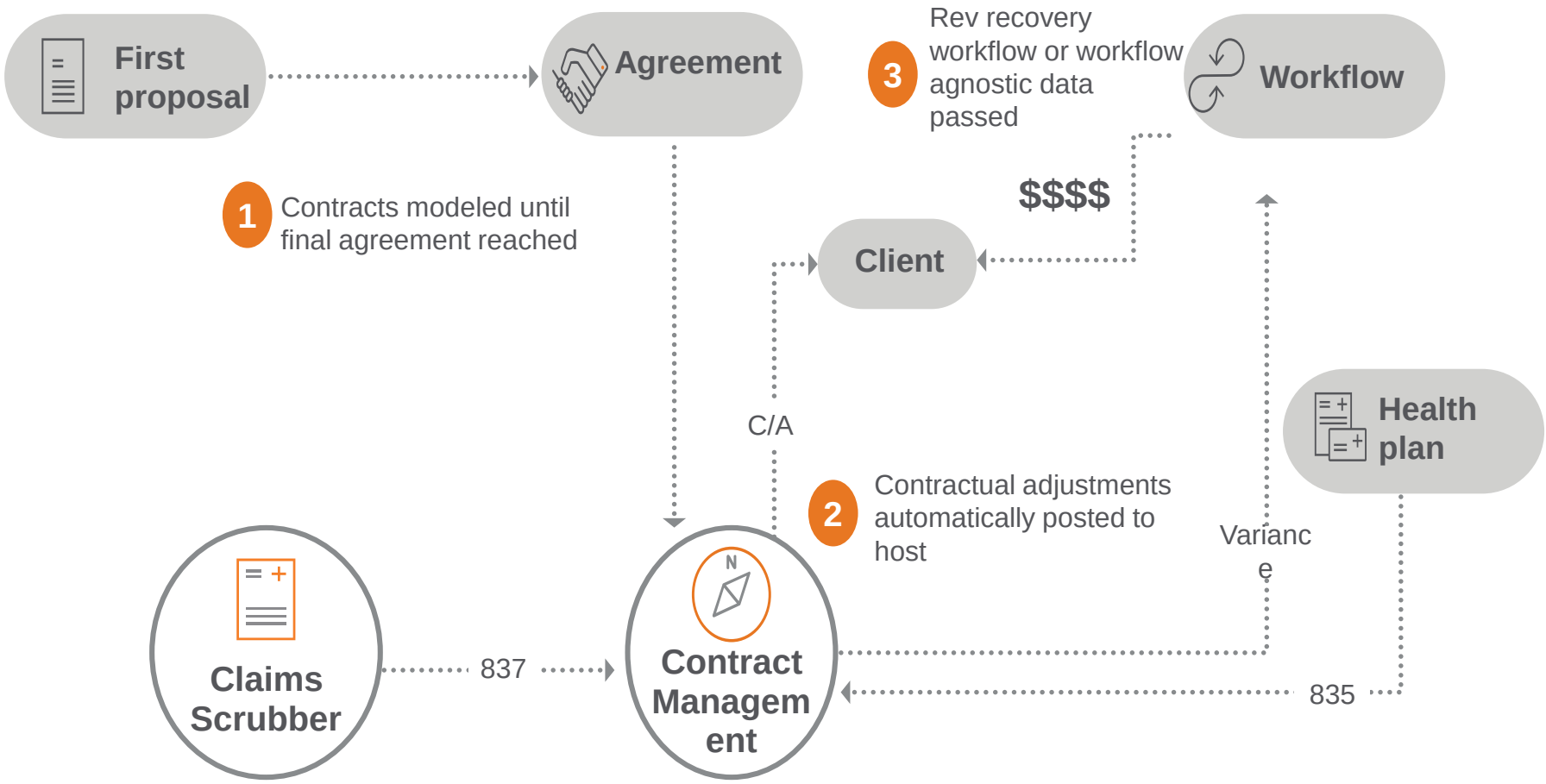
MODEL

Generate unlimited contract **models** to assess ‘what if’ contracting scenarios

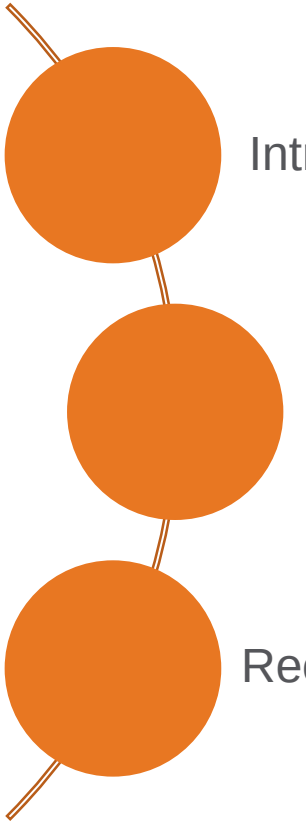
ANALYZE

Combine disparate datasets from across the enterprise to provide an aggregated, normalize data model for robust **analysis**

Maximize results leveraging enterprise contract management



Agenda



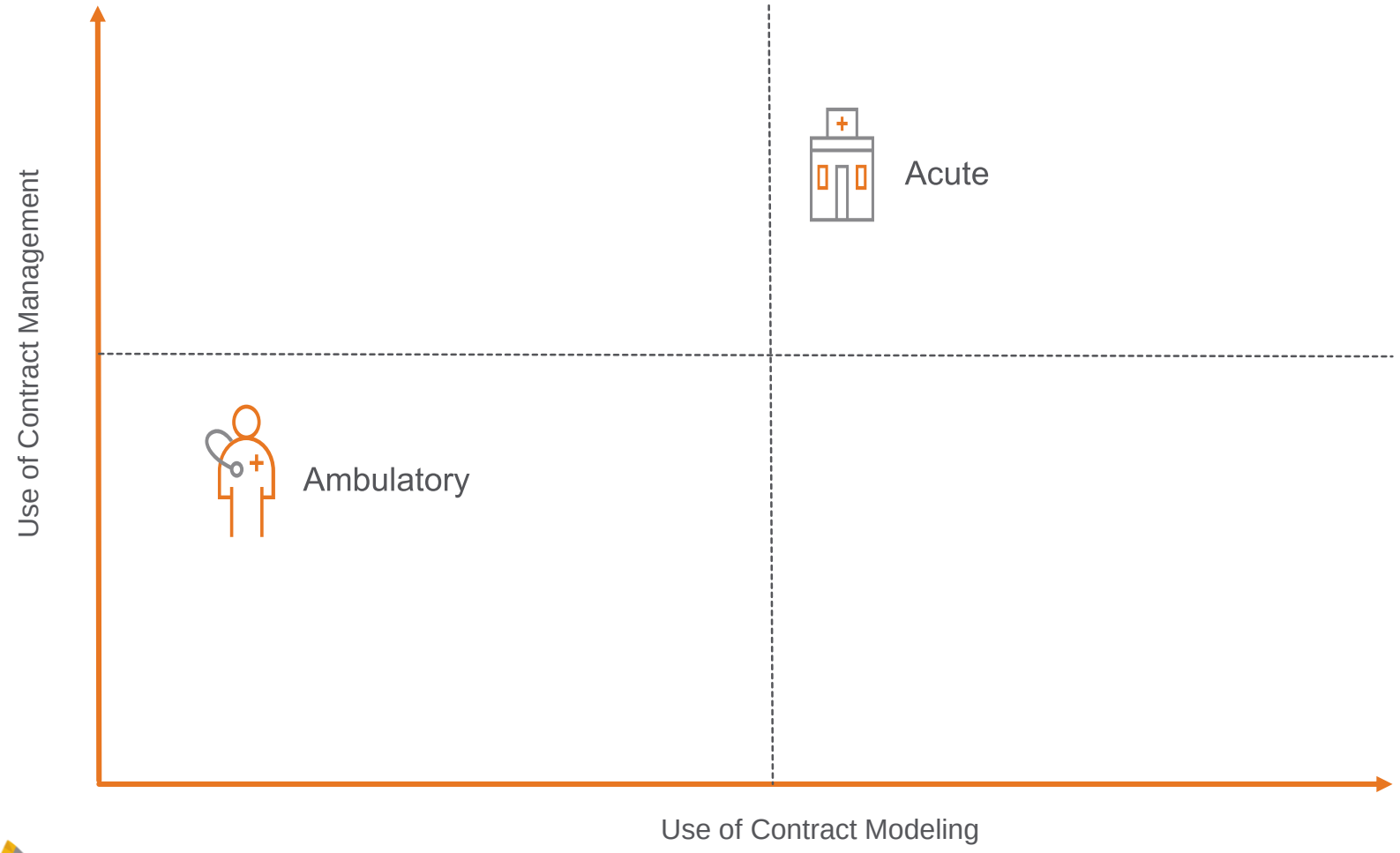
Introduction to contract management

Contract management in ambulatory setting (professional)

Recommendations

Adoption of value drivers still relatively low

In comparison, hospitals are almost fully entrenched



Common misconceptions of professional contracts

Professional reimbursement is not complex, therefore no variances

- **Why?** A lot of profee reimbursement is fee schedule based, therefore less complex.
- **Reality?** Common payment issues unrelated to reimbursement complexity
  - Product mapping
  - Late effective period updates

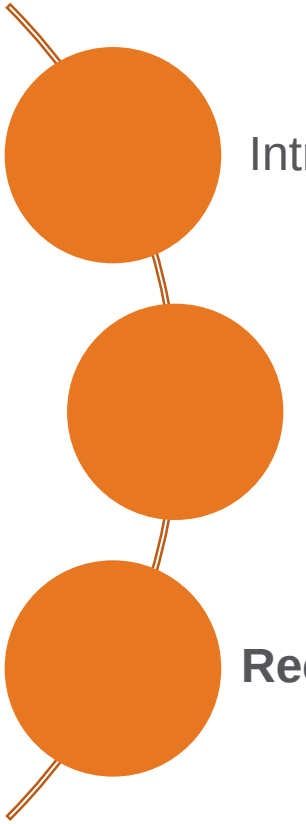
Underpayments do not occur with regularity

- **Why?** Initial implementation of contract management can result in boost in cash, particularly if multiyear issues uncovered.
- **Reality?** Payment is susceptible to a payment defect every time terms update

Professional reimbursement is low dollar, so not worth cost to collect

- **Why?** Professional reimbursement is much lower than hospital.
- **Reality?** Low dollar, high volume allows for easier trending. Underpayments do not need to be worked claim by claim.

Agenda



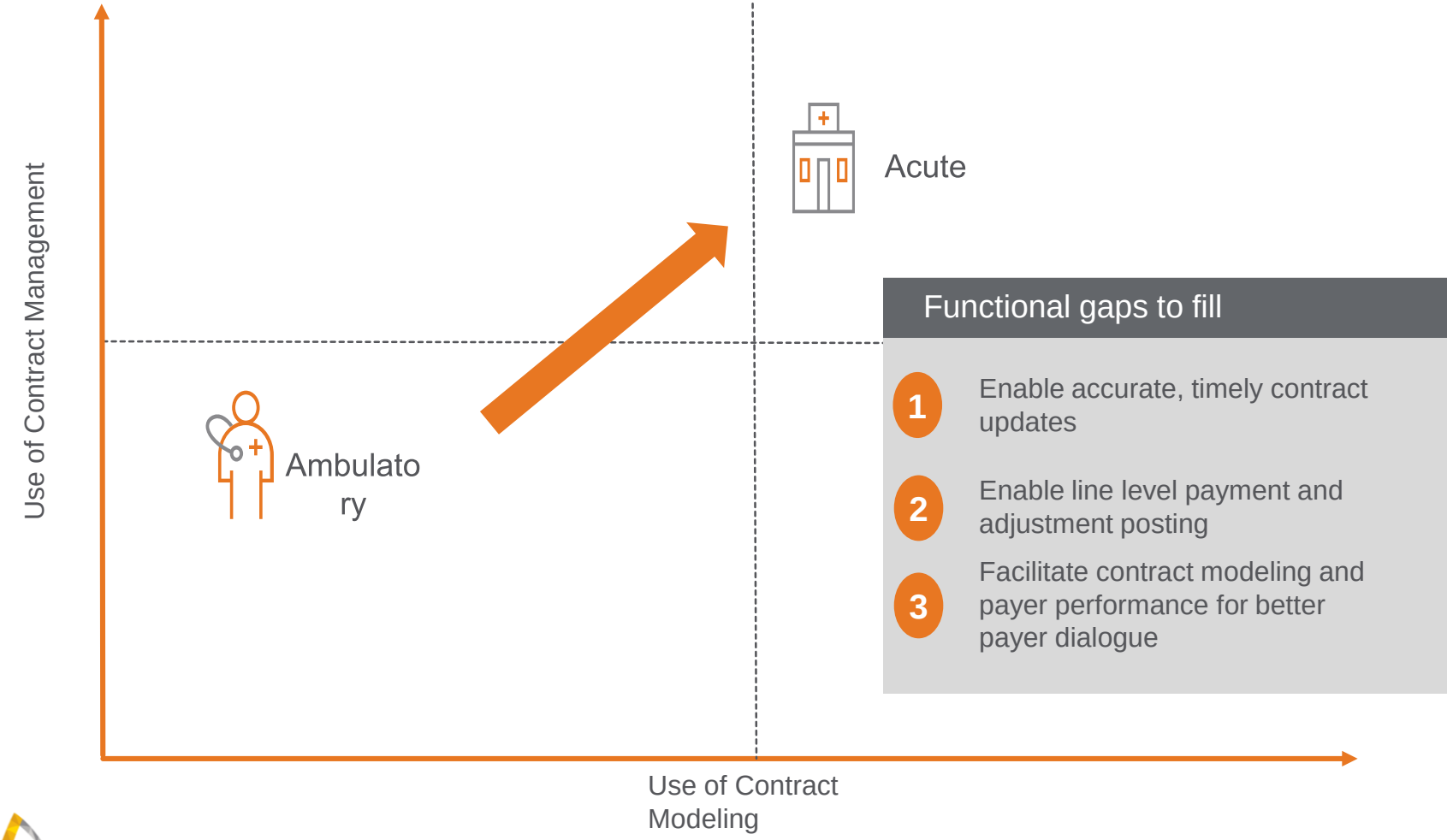
Introduction to contract management

Contract management in ambulatory setting (professional)

Recommendations

Filling the gaps

Keys to better contract performance



Functional gaps to fill

1. Enable accurate, timely contract updates
2. Enable line level payment and adjustment posting
3. Facilitate contract modeling and payer performance for better payer dialogue

OPTUM 360°

What can we do to facilitate this change?

Recommendations

Functionality	Suggested Approach
Ensure accurate and timely contract updates	Advocate for standard and transparent contract format **Bonus:** Format ingestible by technology
Enable line level payment and adjustment posting	Enable capability within host systems as well as interoperability with external systems
Facilitate contract modeling and payer performance	Advocate for revenue cycle / managed care best practice process and technology

Thank you.

Patient as a Consumer

Tim Mills, Alpha II

Moderator: Eric Christ, President of HATA

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"Increased Patient Financial Responsibility – The Consumer Payor" for HATA Membership Meeting

November 13, 2018

Timothy Mills, Chief Growth Officer

Increased Patient Financial Responsibility – The Consumer Payor

- The Growing Patient Responsibility Reality
  - Introduction – The Consumer Payor
  - The evolution of CDHP's to HDHP's
  - Industry statistics (historical and projected)
  - Growing "Consumer Awareness" from CMS
- Impact and implications to the provider/billing office
  - Identifying patient responsibility
  - Implications of poor claims accuracy/increased denials
  - Patient communication, education, and engagement
  - Managing payment options…
- The role of the billing company, consumer payor, and your 3rd party vendors
  - What technologies/services should be considered?
  - What "best practice" recommendation(s) to consider?
  - Enabling your practices with tools and processes
- Questions & Answers (Q&A)

The Growing Patient Financial Responsibility Reality

- The patient is now the #3 **payor** behind Medicare and Medicaid
- This trend has been steadily increasing for more than **17+ years**
- Patient responsibility is expected to climb to **50% of every healthcare** dollar by 2020
- There is a new boss in US Healthcare: the **Consumer Payor**!

Sources:
- McKinsey & Company,
- Centers for Medicare and Medicaid Services (CMS),
- Kaiser Foundation,
- Becker's Hospital Review

Sources:
- University of Minnesota researchers Roger Feldman and Jon Christianson
- PwC (Price Waterhouse Coopers)
- American Hospital Association (AHA)

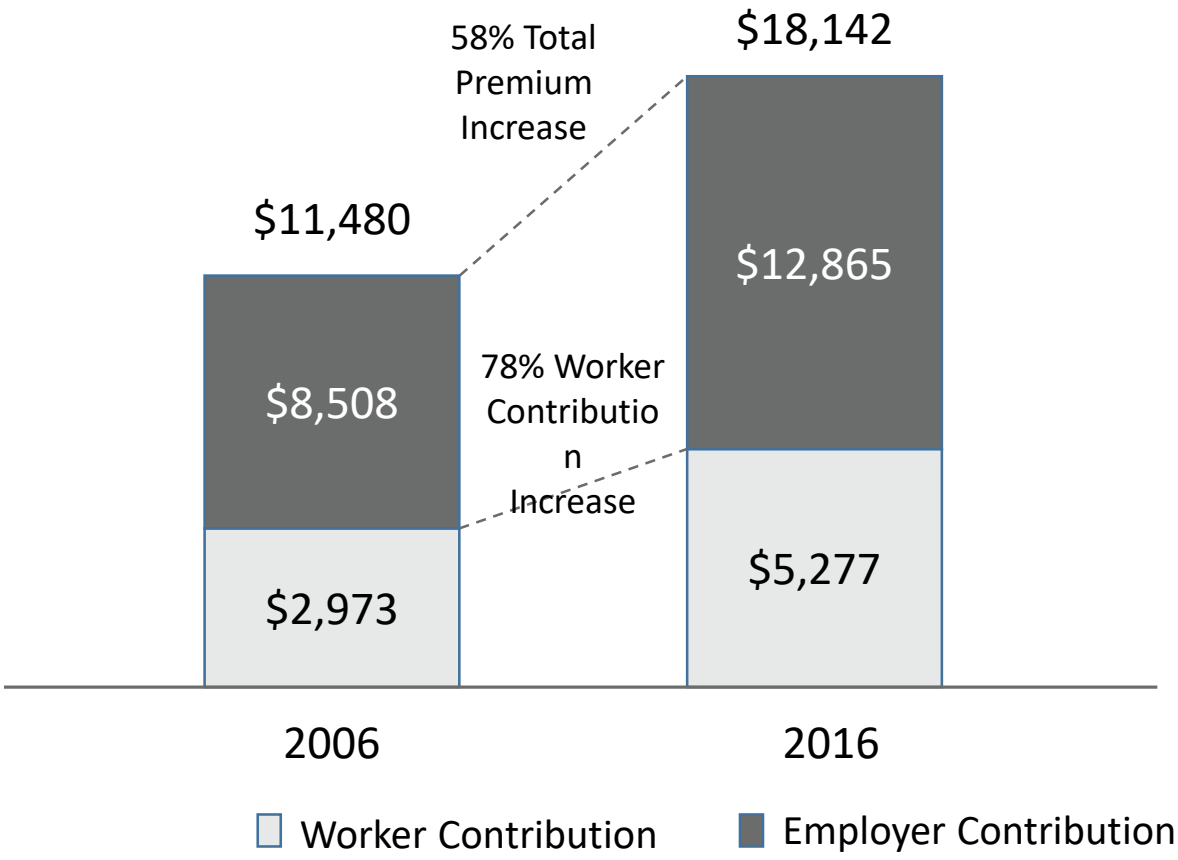
Industry Stats/Facts (Past, Present, and Future)

- The first CDHP's introduced in the late 1990s/early 2000s
- Designed to engage consumers more directly
  - An option to lower premiums vs higher deductibles
  - Health Reimbursement Accounts (HRAs) and Health Savings Accounts (HSAs)
- 2002 CDHP Impact Study
  - Expectation was more **low-risk**, **low-cost** consumers
  - **Income** was the primary driver of CDHP selection, not age or health status
- Continued to grow steadily and was further expanded as ACA was passed in 2010
- Many physician offices ill-equipped to keep up

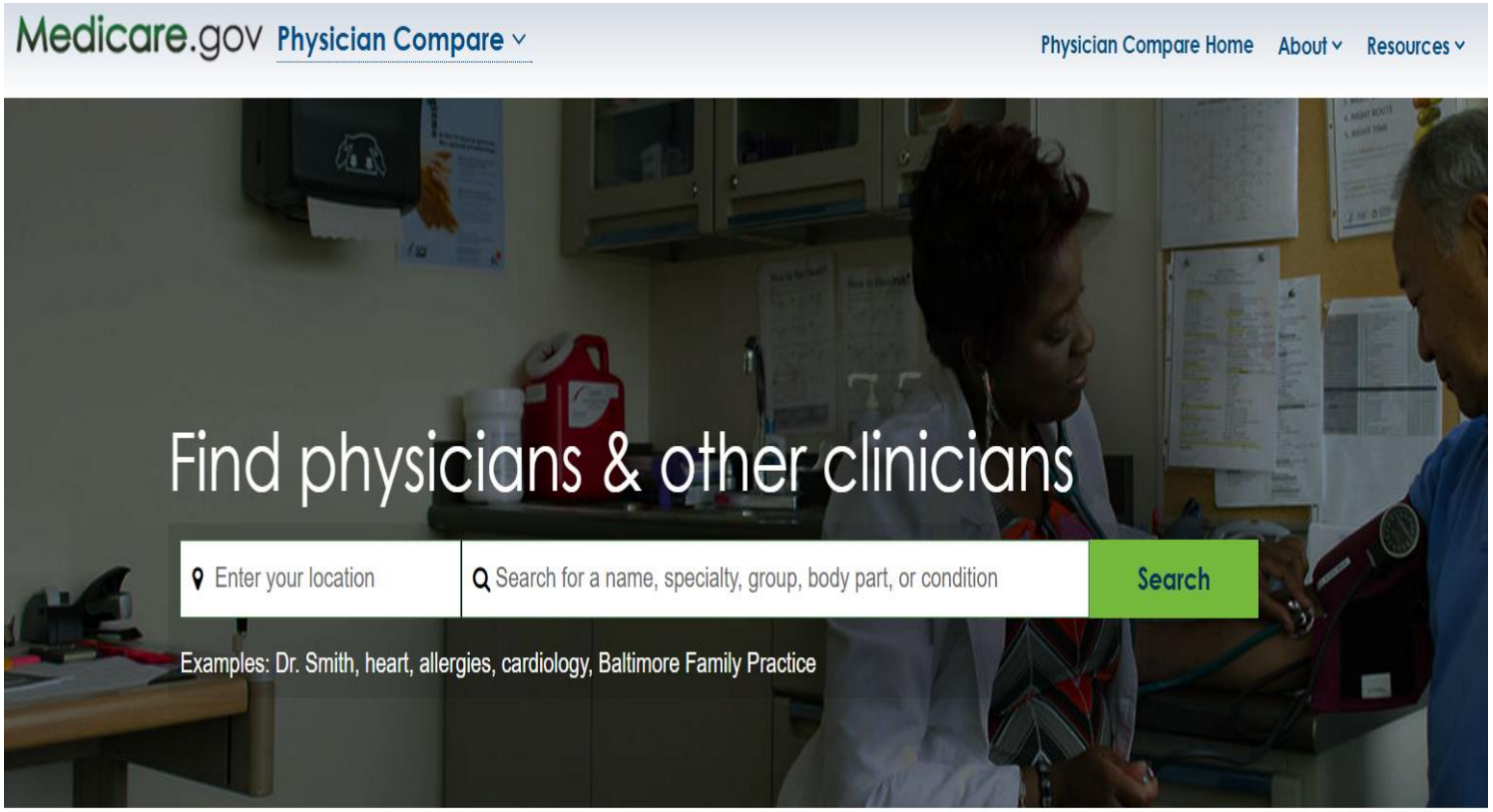
Industry Stats/Facts (Past, Present, and Future)

- The most widely adopted CDHP is the High Deductible Health Plan **(HDHP)**
  - Combined with an HSA
- Both HDHPs and HSA's have become highly regulated, for 2018:
  - Minimum deductible for HDHP's $1,300/$2,600
  - Out-of-pocket max for HSA-qualified plans is $6,550/$13,100
- Proponents – shifting costs to consumer will motivate more prudent healthcare choices
- Critics – deductibles are unrealistically high and force consumers to forego needed care

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage 2006-2016



Merit-Based-Incentive Payment Systems (MIPS)



- Consumer transparency by CMS — The Physician Compare Website
- CMS has created a star rating system (1-5) for Medicare physicians

Merit-Based-Incentive Payment Systems (MIPS)

CMS will **publicly report**

- the **final overall (composite) MIPS score**,
- Individual and Group for **each performance category,** and
- periodically post aggregate information on this data.

Questions to ask your clinicians:

- *"Am I concerned only about avoiding a negative adjustment?"*
- *"If I score a '15,' how does that look related to a score of '85'?"*
- *"What public reputation do I want for quality performance and reporting?"*

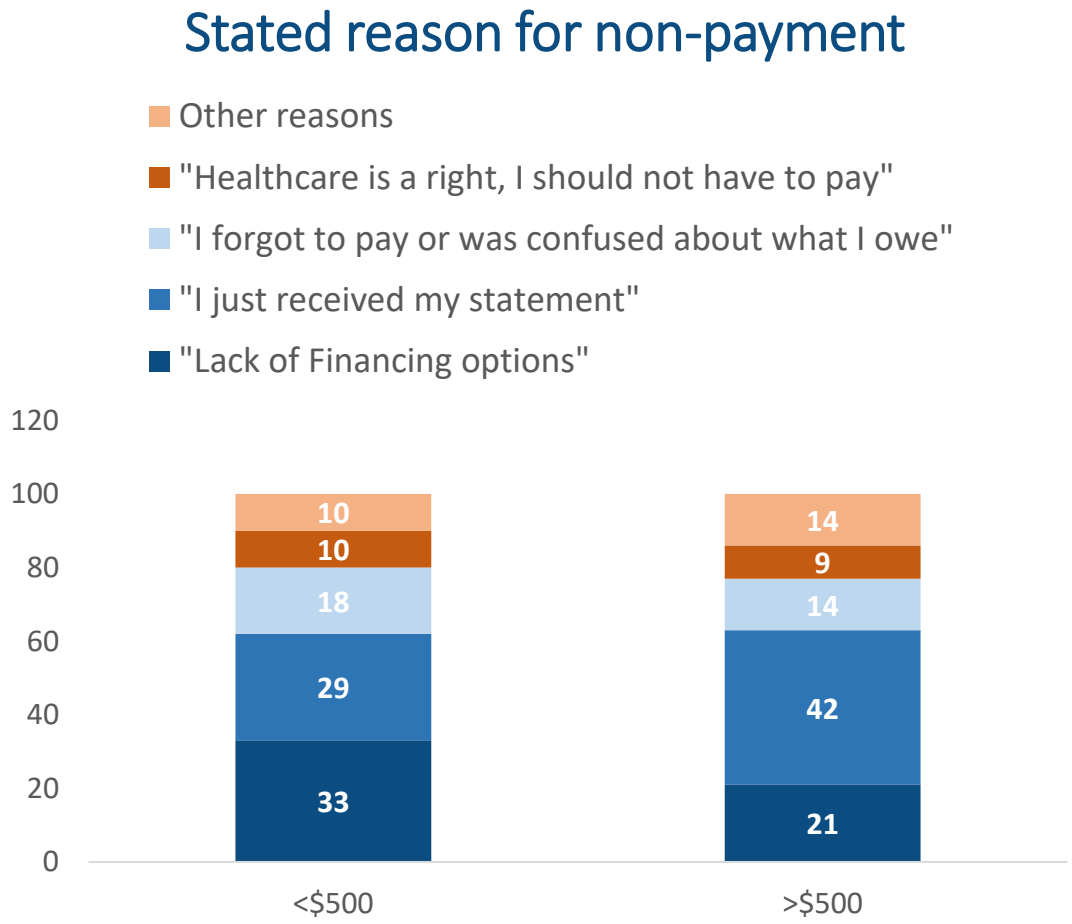
MIPS Scoring means more than just "incentive payments"

Impact and Implications to the Provider/Billing Office

Identifying patient responsibly sooner than later

- Remember the days, *"Mary, don't pay attention to our first statement, because we really wont know what you owe until at* least *the 2nd billing cycle."*
- Frankly, we in healthcare are somewhat culpable…
- Technically, the patient is responsible for 100%
- Factors that impact determining patient portion:
  - Coordination of benefits (primary, secondary)
  - Co-pays, co-insurance, deductibles, previous balances
  - Read your Explanation of Benefits (EOB)
  - Needed referrals or authorizations
  - Insurance information up-to-date

Reasons for non-payment from McKinsey Report



Communication becomes critical

Implications of poor vs good claims accuracy

- Poor claims accuracy implications:
  - Increases administrative burden
    - Chasing the denial reason and refiling the claim
  - Increases avoidable administrative costs
    - Approximately $15 - $25 in total costs
  - Possible missed coding (over/under)
  - Impacts communication timing with the patient
  - Reduces cash flow (stress)
- Good claims accuracy implications:
  - Administrative resources can focus more on patient engagement and satisfaction
  - Increases confidence in patient communication

Patient communication, education, and engagement

- Understanding your consumers **“ability”** and **“willingness”** to pay is critical
- Consumers WANT communication on what they owe and what options are available to pay!
  - Aligning patient and provider interests
- Many consumers are frustrated that the only bill they can not ***“easily”*** pay is their medical bill
  - Virtually everything else has varied options for payment
    - Online, payment plans, financing, Apple Pay, etc.
- Not being proactive with payment discussions creates confusion and frustration and leads to **slow-to-low pay**
- Happy patients = paying patients = **lower collection costs**

Patient communication, education, and engagement

- According to the AHA, providers **collect 50-70%** of small dollar liabilities – and just **10% from self-pay**
- Perception is that many patients lack the resources to address their healthcare debt out-of-pocket
- But studies show for annual liabilities of <$1,000, **74% of consumers** are both **willing** and **able** to make payment *arrangements*.
  - 38% of consumers could cover $500 medical bill with cash on hand
- So, proactive engagement and communication with the patient is vital and frankly **consumer desired**

Providing payment options…and options…

- Healthcare costs are often **unplanned expenses**
- Offer patient-friendly financing options…options
- Structured, interest-free payment plans
  - Ability to make plans for the unplanned expenses
- Consider using multiple channels to pay
  - Research suggest consumers use three different bill payment methods each month
  - Mail-in remittance
  - Payment by phone (automated)
  - Online and mobile payments
  - Flexibility to change payment methods

The role of the billing company, the consumer payor, and your 3rd party vendors

What technologies/services should be considered

- Claim and encounter editing tools to drive cleaner claims the first time
  - Reduce denials, improve cash flow, reduce administrative burden
  - Better claims accuracy leads to improved communication with consumers payment portion
- Engage with you PM/RCM/Clearinghouse vendor on what options are available for claims accuracy
  - Consider moving claims editing earlier in the PM/EMR workflow to identify errors before claims are rejected

What technologies/services should be considered

- Consumers are embracing **Online** and **Mobile** payment tools *(convivence is key)*
  - Patients can pay quickly – anytime from anywhere
  - Nearly **70% of all bills** are paid online/mobile
  - Since 2012 **mobile bill payers have grown by 427%**, and **automated payment plans increased by 376%**
  - **93% of consumers** would pay online/mobile if given the option
- Online estimation, payment plan administration, and on-demand instructions (FAQs)
  - Consider auto payment plans above X balance
- No longer a need-to-have, but a **MUST HAVE**

What technologies/services should be considered

- Patient statement functionality is evolving and needs attention:
  - Print – using graphics, bold fonts, increased scale to ensure that **online is the first option patients see**
  - eStatements – email that **includes links** to online payment options and/or payment plan options
- Consider **"Guest Pay"** options to augment a more formal Patient Portal
  - Guest pay websites don't require consumers to create a username/password or even "log-in"
  - Patient simply enters unique account information from the statement
  - Payment is easy, fast, and convenient

What technologies/services should be considered

- Patient estimation tools:
  - Typically use eligibility verification to gather needed and pertinent patient data
    - Co-pay, co-insurance, deductibles, etc.
  - View into **payor contracts** for cross-reference
  - Allows for **secure storage of payment** methods to be used for payments or payment plans
    - **Payment Card Industry Data Security Standard** (PCI DSS)
  - Utilizes the ERA to **identify patient portion** and then provides options for payment
- Engage with your PM/RCM vendors or other specialized patient payment vendors for what features and/or services are available

What tools and best practices should be considered

- Patient Portals are much more commonplace, a part of MIPS Advancing Care Information (ACI)
- But what functional and options are available to support patient financial responsibility?
  - Secure storage of payment information
  - Payment card swipe functionality
  - Virtual card swipe functionality
  - Payment plan management - Patient
    - Direct patient engagement
  - Payment plan management – Admin option
    - Only provide payment plans over a certain $ threshold
  - Integrated mobile payment aps, if available

Enabling the practice with tools and processes

- Consumers **WANT communication** on what they owe and what options are available to pay!
  - Aligning patient and provider interests
- Better **claims accuracy** the first time
- Push for maximum **Patient Portal** functionality
- Alternative **Online** payment options, plural
- **Mobile** payment options, if not through your portal solution, then investigate 3rd party
- Statements and eStatement tools
- Enable **Guest Pay** options
- Consider **Patient Estimation** tools

Summary – What are the three (3) most important?

1. Patient Engagement
   - early and often
2. Education
   - administrative staff and patient
3. Communication
   - Proactive, proactive, proactive

QUESTIONS?

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The Future Is Wide open Artificial Intelligence In The Revenue Cycle and Other Emerging Innovations

Brad Gnagy, Healthpac Computer Systems, Inc.

Moderator: Eric Christ, President of HATA

HATA
HEALTHCARE ADMINISTRATIVE TECHNOLOGY ASSOCIATION

WRAP UP
Next Steps

Tammy Banks, Vice President of HATA

HATA
HEALTHCARE ADMINISTRATIVE TECHNOLOGY ASSOCIATION

THANK YOU ALL!