MAPAM FALL MEETING

Patient Financial Experience

OCTOBER 23, 2023

Agenda

Introductions

RACHEL VERVILLE

Managing Director,
Management Advisory Services

EDUCATION

B.A., Worcester State University

PROFESSIONAL SUMMARY

Rachel is a dynamic and accomplished senior healthcare executive who is passionate about transforming healthcare to serve all people. With more than 30 years in the industry, she has extensive experience in healthcare operations, revenue cycle services, reimbursement, policy, financial management and technology. As leader of BDO's revenue cycle practice, Rachel's transformational initiatives are guided by doing what is right for the patient first and foremost and the creation of a culture of excellence. Guided by these principles, her revenue cycle management approach seeks to integrate clinical and financial operations by harmonizing people, process, and technology.

Prior to joining BDO, Rachel served as Chief Revenue Officer at Allegheny Health Network, the provider arm of Highmark Health, a $20 billion integrated health and wellness organization that includes one of America's largest Blue Cross Blue Shield insurers. Prior to AHN, Rachel served as Vice President Revenue Cycle for LCMC Health System in New Orleans, and she has also held leadership positions at Mass General Brigham, Boston Medical Center, and Elliot Health System.

PROFESSIONAL AFFILIATIONS

American College of Healthcare Executives, Member
Healthcare Financial Management Association, Member, MA-RI Chapter

BDO Healthcare Consulting Services

BDO's healthcare consulting services provide a strong combination of strategy, operations management, and digital solutions focused on helping provider organizations improve their ability to deliver high quality care, enhance the patient experience, and drive financial improvement.

WHO WE SERVE

We annually serve 1,000+ healthcare clients, including leading hospitals and health systems in the U.S.

We work with many of the largest for profit and nonprofit health systems around the country

We work with a significant number of healthcare-focused private equity firms around the world

BDO Healthcare Consulting Services

FINANCIAL IMPROVEMENT

- Clinical Integration and Alignment
- Physician Practice Management
- Department and Service Line Leadership
- Labor Advisory and Augmentation
- Revenue Cycle Services:
  - Interim Leadership
  - Transformation and Operating Model Design
  - Performance Improvement
  - Cash Acceleration
  - Billing System Optimization

CLINICAL INNOVATION

- Experience and Digital Patient Engagement
- Access Transformation and Enhancement
  - Scheduling Template Optimization
  - Call Center Design and Leadership
- Value-based Programs
- Referral Management Transformation
- Population Health Strategies
- Service Line Strategy and Growth
- Revenue Integrity, CDI, Coding and Compliance

DIGITAL TRANSFORMATION

- Digital Strategy
- IT Strategy and Vendor Selection
- Implementation and Upgrade Services
- Project and Change Management
- Application Management and Rationalization
- EHR Extension to Clinical Affiliates
- Business Intelligence and Analytics

What is the Patient Financial Experience?

What if the Airline Industry Was Like Healthcare?

https://youtube/jZmDq9VxjgU

What Is the Patient Financial Experience?

Simply put, the patient financial experience involves all patient communication and interaction regarding payment for healthcare services. But the current landscape is anything but simple. The landscape is becoming more and more complicated for patients and families – a call to arms for providers – and the stakes are high.

Consumer Health Impacts and Stress*

- **71%** of consumers find reconciling a billing issue between their payer and provider stressful
- **58%** find paying a healthcare bill to be stressful
- **56%** find understanding what they owe to be stressful
- **47%** say well-being or healing has been negatively impacted by difficulty paying a healthcare bill

*CEDAR 2024 HEALTHCARE FINANCIAL EXPERIENCE STUDY

Payer and Provider Reputation

Patient Stress and Health

Regulatory Implications

FINANCIAL HEALTH

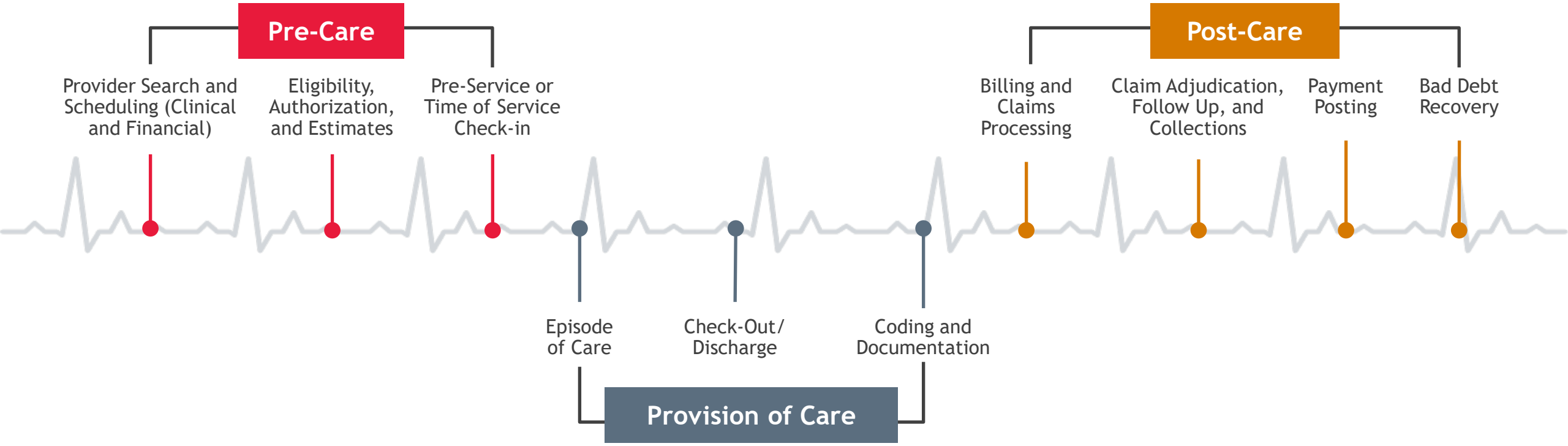
Consumer Choice*

- **58%** have revisited a provider because of a previous positive billing experience
- **57%** say previous discount options impacted their choice to use providers again
- **49%** have left a positive review for provider if they had a good billing experience
- **41%** of consumers have left a negative review of their provider due to a negative billing experience
- **38%** have switched healthcare providers due to a negative billing experience

*CEDAR 2024 HEALTHCARE FINANCIAL EXPERIENCE STUDY

What is the Patient Financial Experience?

There are 10 key process areas across the revenue cycle continuum that may impact the patient financial experience. While there are many risks to the patient financial experience along this continuum, there are just as many opportunities.



Note: Key moments above are not exhaustive

Impacts and Why It Matters

Patients can experience significant pain points during their care journeys, which can impact the likelihood of paying and/or potentially impact where they seek care.

Patient Pain Points

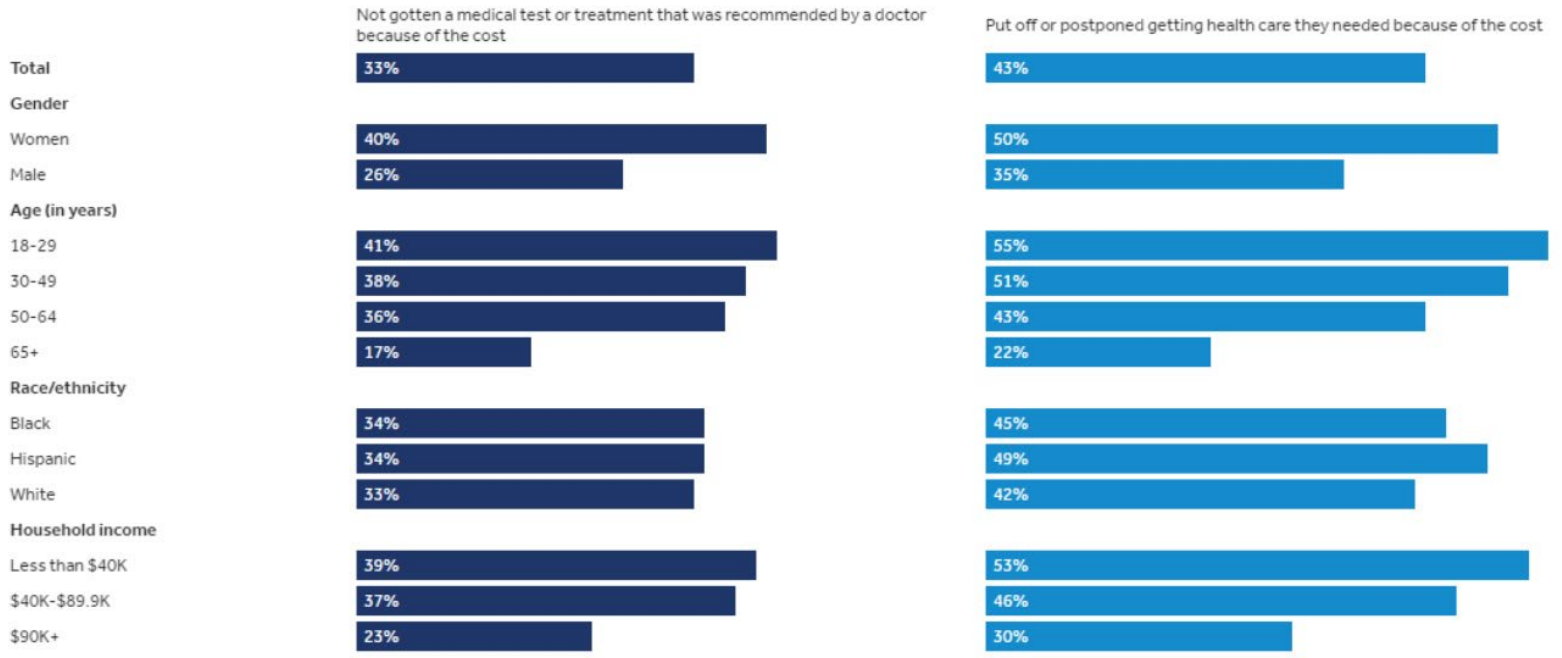
Pre-Care	Provision of Care	Post-Care
▶ Confusion related to coverage, benefits & associated patient responsibility amounts ▶ Lack of clarity around price transparency, including awareness of patient responsibility (i.e., copay, deductible, coinsurance) ▶ Coverage and financial assistance options	▶ Lack of understanding of medical terminology, plan of care ▶ Manual & complex administrative requirements ▶ Lack of consistent payment options ▶ Payment process complexity	▶ Inconsistent payer and provider communications ▶ Timeliness of patient billing ▶ Unaffordable/unexpected out-of-pocket costs ▶ Unpleasant collections process

Impacts & Why It Matters

Affordability and Delays in Care

Post pandemic the rates of individuals reporting that they have delayed or foregone care due to cost continues to grow. Peterson-KFF Health System Tracker data illustrates that in early 2022, one in three adults said they or a family member did not get care due to cost.

Percent who say, in the past 12 months, they or another family member living in their household has put off, postponed or not gotten care due to cost, 2022



Impact and Why It Matters

Patent Confusion: Coverage, Benefits, and Out-of-Pocket Expenses

Patients often report confusion related to insurance coverage, benefits and associated patient responsibility requirements.

Insurance Verification, Benefits, Authorization and Estimates

Types of Plans

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Exclusive Provider Organization (EPO)
- High Deductible Health Plan (HDHP)
- Point of Service (POS)

Patient Responsibility Factors

- Deductibles
- Out-of-Pocket Maximums
- Copayments
- Coinsurance
- Coverage Limits
- Provider Network

43% of consumers say clear explanations about how deductibles and out-of-pocket maximums impact the bill would encourage them to pay faster

42% of consumers say real-time, understandable explanations for any services that were denied would encourage them to pay faster

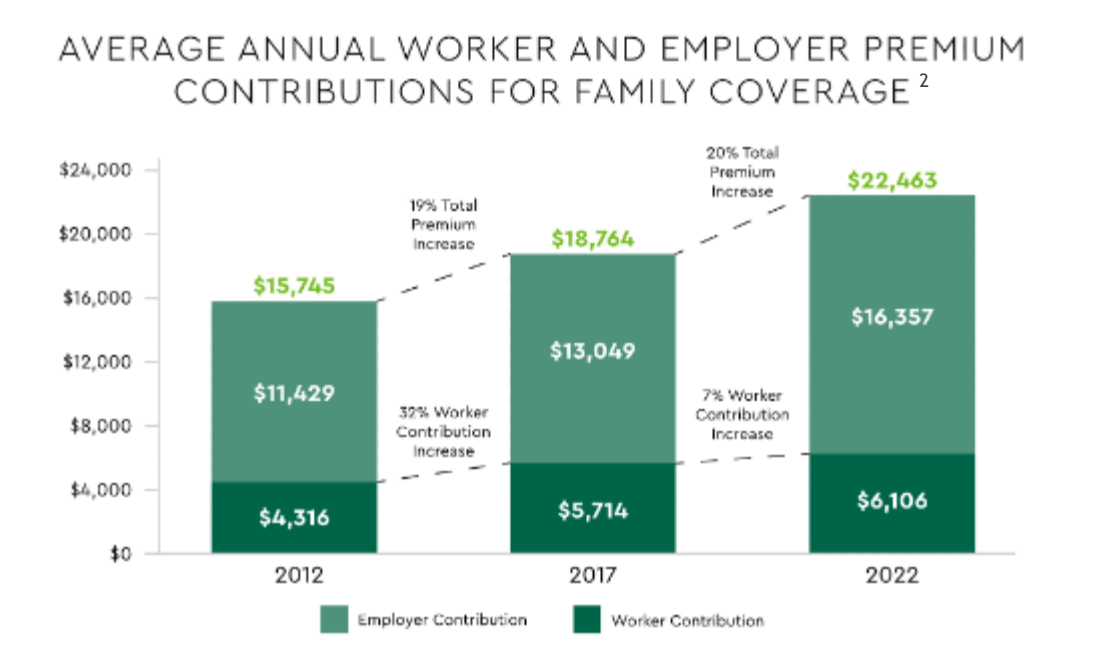
CEDAR 2024 HEALTHCARE FINANCIAL EXPERIENCE STUDY

Impact and Why It Matters

Insurance coverage trends have shifted to high deductible and cost sharing plans which has resulted in higher out of pocket costs for patients.

Metric[1]	2015	2020
High-Deductible Plans	34%	53%
Average Deductible	$991	$1,699

Additionally, there has been an increase in non-contracted payers that patients believe are real health insurance. Some providers are no longer offering courtesy billing to help educate patients and push back on these types of payers.



FOOTNOTES

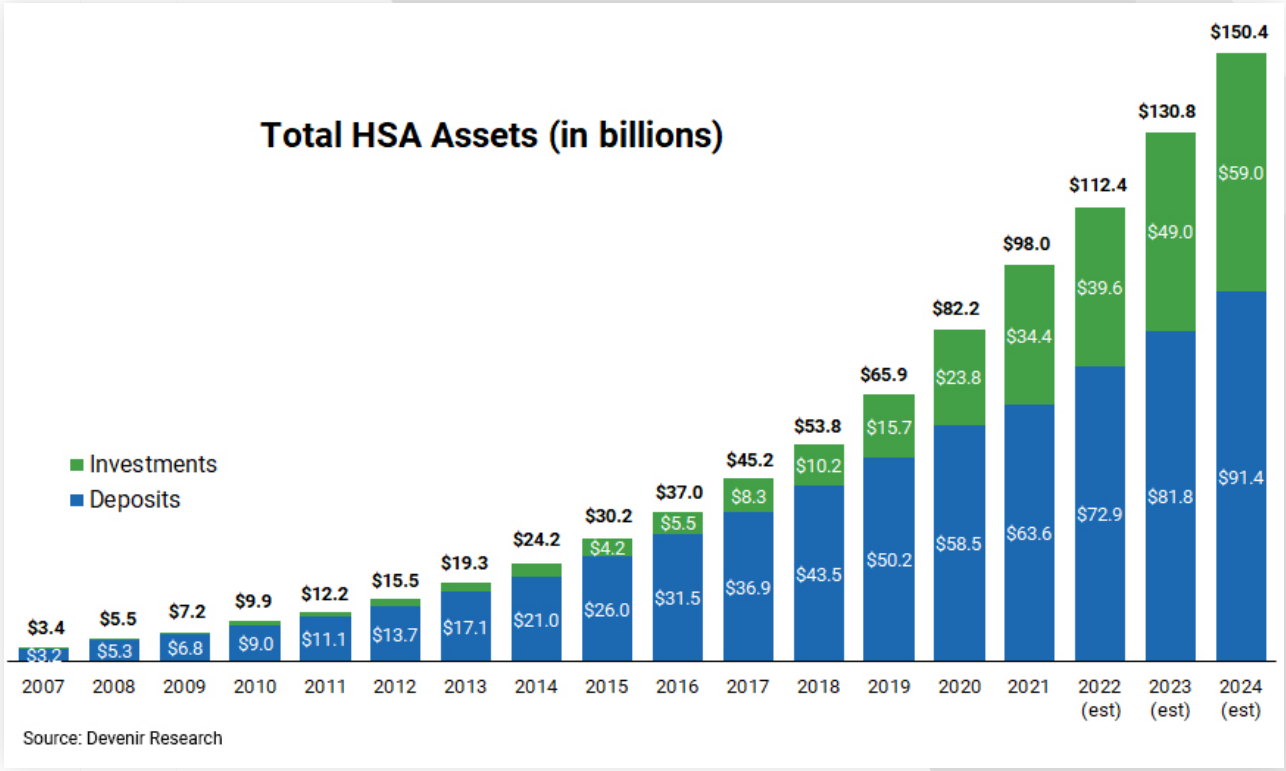
1. Managed Healthcare Executive April 24, 2022, How to Relieve the Pressure of High-Deductible Healthcare on Patients (managedhealthcareexecutive.com)
2. CommerceHealthcare January 23, 2023, Healthcare Finance Trends for 2023: Multiple Intersecting Challenges | CommerceHealthcare

Impact and Why It Matters

HSA and FSA Accounts

As patient out-of-pocket costs continue to become an increasing part of the overall reimbursement pie, consumer confusion over HSA and FSA accounts has become a more vexing problem.

- By the end of 2024 $150B in assets is estimated to be held in HSA balances, according to research conducted by Devenir, a national HSA investment solutions company
- In recent years, more than 40% of workers lost unspent FSA dollars – almost $3B per year – according to the Employee Benefit Research Institute (EBRI) as reported to *Money Magazine*
- Compounding the problem, Cedar, a healthcare patient financial experience technology company, reports that:
  - **38%** do not know how to open an account or have not gotten around to it
  - **35%** forget they have an account
  - **34%** have been put off using their account by a bad experience
  - **33%** do not know where their accounts are
  - **29%** do not know how to pay bills out of an account



Financial Advocacy, Vendor, and Technology Options

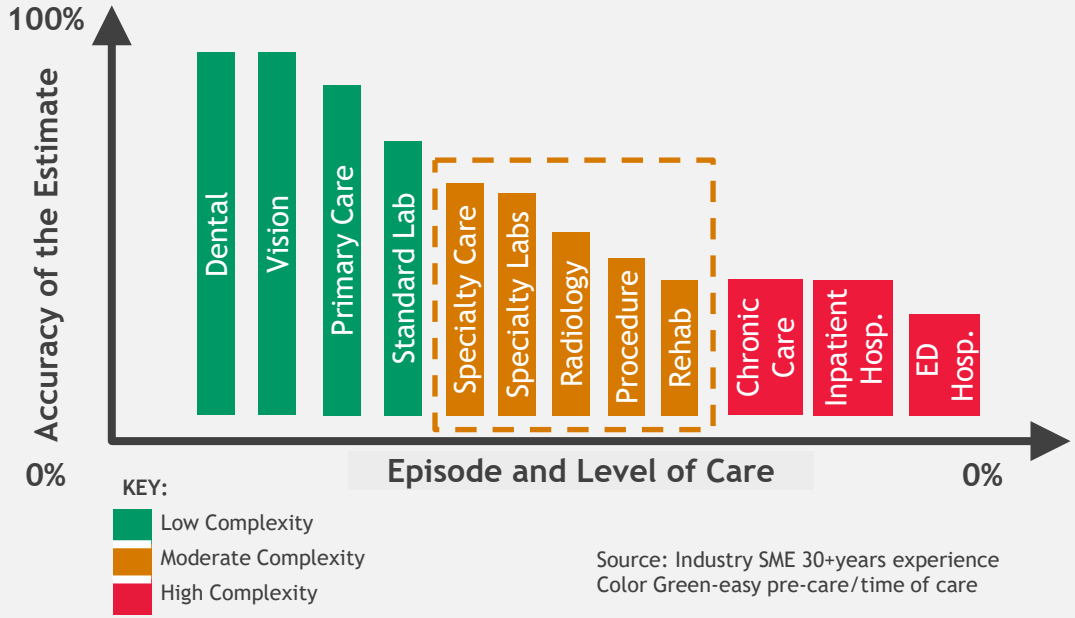
Potential Options and Approaches

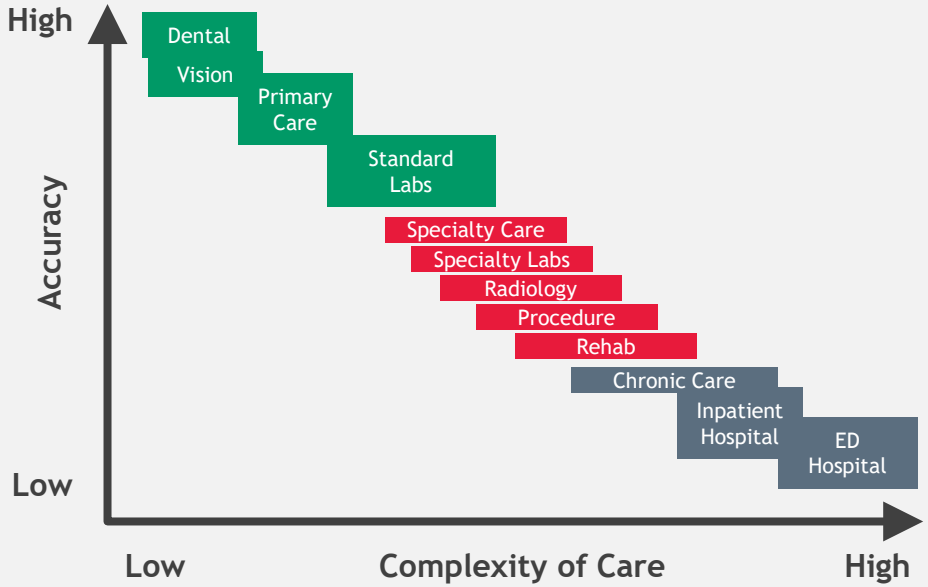
There is no silver bullet solution for improving the patient financial experience. A multi-pronged approach will provide the best results, including leveraging technology and vendor partners.

Option	Overview
Real Time Eligibility (RTE) and Coverage Discovery	Leverage a third-party coverage and benefits verification platform to run real-time and integrate with billing system to improve accuracy of patient out-of-pocket cost estimates and help with financial advocacy
Patient Price Estimation	Implement and automate price estimation technology through patient portal, during scheduling, and upon patient request
Digital Payment Options	Leverage patient portals, integrated technology, and vendor support to automate communication and collection of patient balances, including HSA, FSA, HRA, bank account, credit/debit cards, social payment apps, financing options, and payment plans
Point-of-Service (POS) Collections	Collect payments prior to or at time of service to avoid payment delays and additional costs
Financial Advocacy Program	Assist patients with determining eligibility for private and public benefits, financial assistance, and/or payment plan terms leveraging automation, vendor support, and a structured decision tree approach

Patient Care Estimate Accuracy Spectrum

Cost estimate accuracy varies by the type/level of care making upfront cost estimates challenging for some services



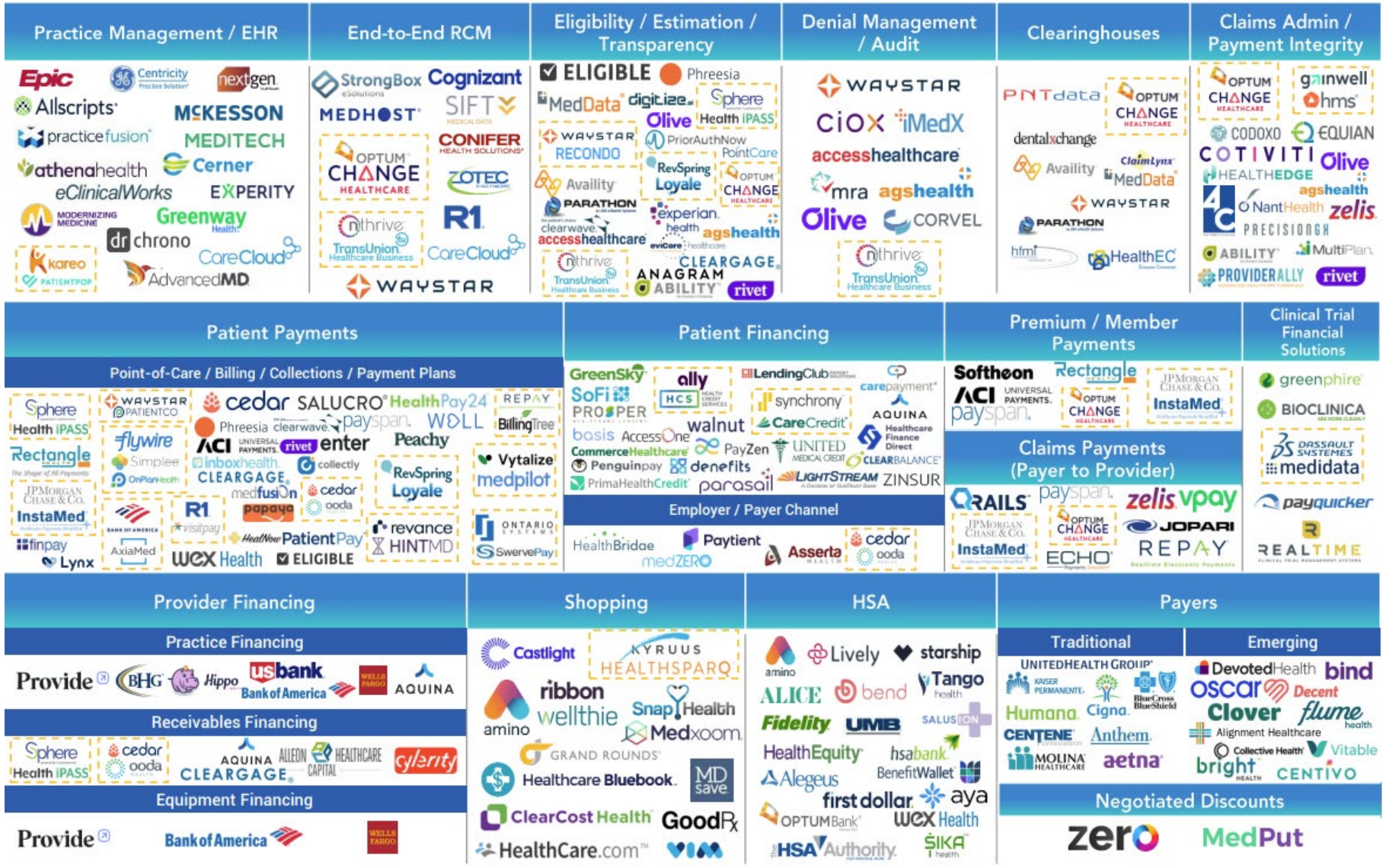


- The **accuracy of estimates** is dependent on the **level of care** the patient receives and the **proficiency of the team** providing the estimate in a timely manner and communicating in a manner the consumer/patient can understand
- For certain types of care, estimates can approach 100% accuracy

- Services that have a high estimate accuracy clearly identify the scope and level of care before care is provided.
- As service complexity changes with level of care, the deviations grow exponentially.
- For moderate complexity services there is potential opportunity to leverage internal payer transparency data to create more accurate patient estimates.

Vendor Options

The market is very crowded, so determining what assistance you need and what services the vendor provides is integral to identifying the appropriate partner(s).



Patient Payment Opportunities and Insertion Points for New Vendors

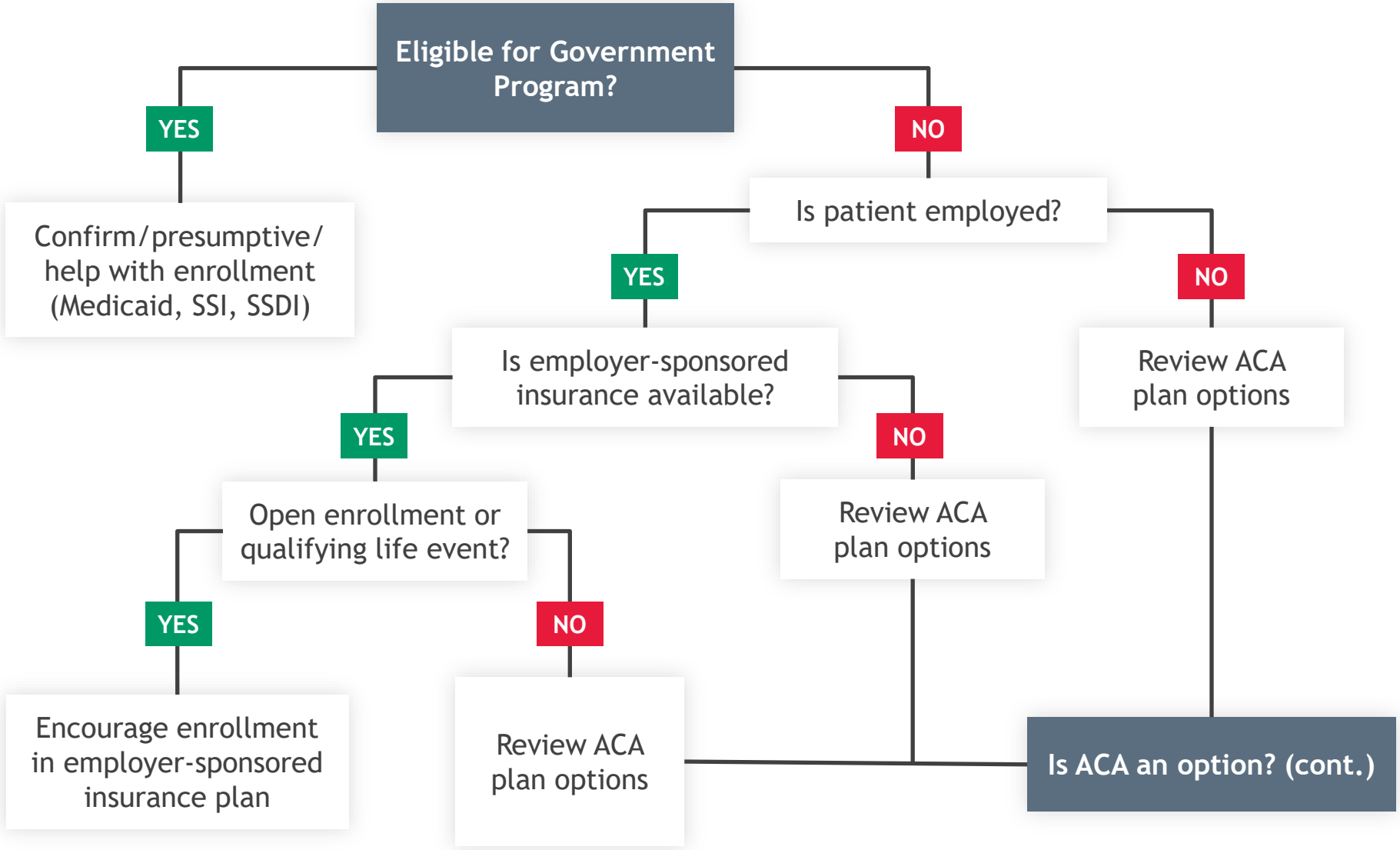
The value proposition from these insertion points centers on improving patient experience and overall collections to the provider (i.e., 'increasing the pie').

Patient Payment Opportunities across the patient journey

	Pre-Care			Provision of Care	Post-Care	
	Scheduling	**Eligibility, Authorization and Estimates**	**Pre-Service or Time of Service Check-in**	**Check-out/ Discharge**	**Follow Up (Collections)**	**Bad Debt Recovery**
Value Proposition	▶ Drive patient / provider **satisfaction and engagement** ▶ Reduce patient **appointment wait times** ▶ Increase **patient retention** ▶ Optimize **appointment capacity** with patient demand	▶ Enhance patient engagement and overall **patient financial experience** ▶ Increase **patient confidence** in adopting digital pay option ▶ Improved patient **balance collection performance** ▶ Improve **Days in A/R**	▶ Increase patient and provider **satisfaction** ▶ Improve patient **balance collection performance** ▶ Increase **revenue / patient retention** ▶ Reduce **workflow burden** on front desk staff/ reduce patient registration time	▶ Improve patient **balance collection performance** ▶ Reduce **workflow burden** on check out / discharge staff ▶ Improved patient **retention / revenue** enhancement ▶ Enable access to **clinical / data analytics**	▶ Improve patient **balance collection performance** ▶ Enhance overall **patient financial experience** ▶ Reduce **bad debt** write offs	▶ Improve **bad debt recoveries** ▶ Leverage current insurance card information to **improve collection rate**
Potential Insertion Points	▶ Access to provider directories to facilitate provider selection ▶ Patient self-scheduling ▶ Digital registration ▶ Patient portal ▶ Smart Shopper Steerage before Scheduling	▶ Real time eligibility ▶ Text to pay ▶ Accurate patient balance estimates ▶ Patient eligibility and enrollment services ▶ Coordination of collections with Patient estimates ▶ ID Cards – QR Codes	▶ Mobile or in office check-in/required registration document collection ▶ Clinical intake ▶ Accurate patient balance estimates ▶ Collecting in advance of service ▶ Credit card on file, including HSA, FSA ▶ Smart wallet technology linked to card on file	▶ Patient portal ▶ Next appointment scheduling ▶ Credit card on file ▶ HSA/FSA card acceptance ▶ Patient eligibility and enrollment services ▶ Payment plans/financing options ▶ Reporting / analytics	▶ Provider's patient portal ▶ Text to pay/mobile app functionality ▶ Payer portal (member pays provider) ▶ Payer integration to support single statement ▶ Smart wallet technology linked to card on file ▶ "Okay to pay" (snap pic and pay)	▶ Collection agency's patient portal ▶ Text to pay/mobile app functionality ▶ Payer portal (member pays provider) ▶ Payment plans/financing options

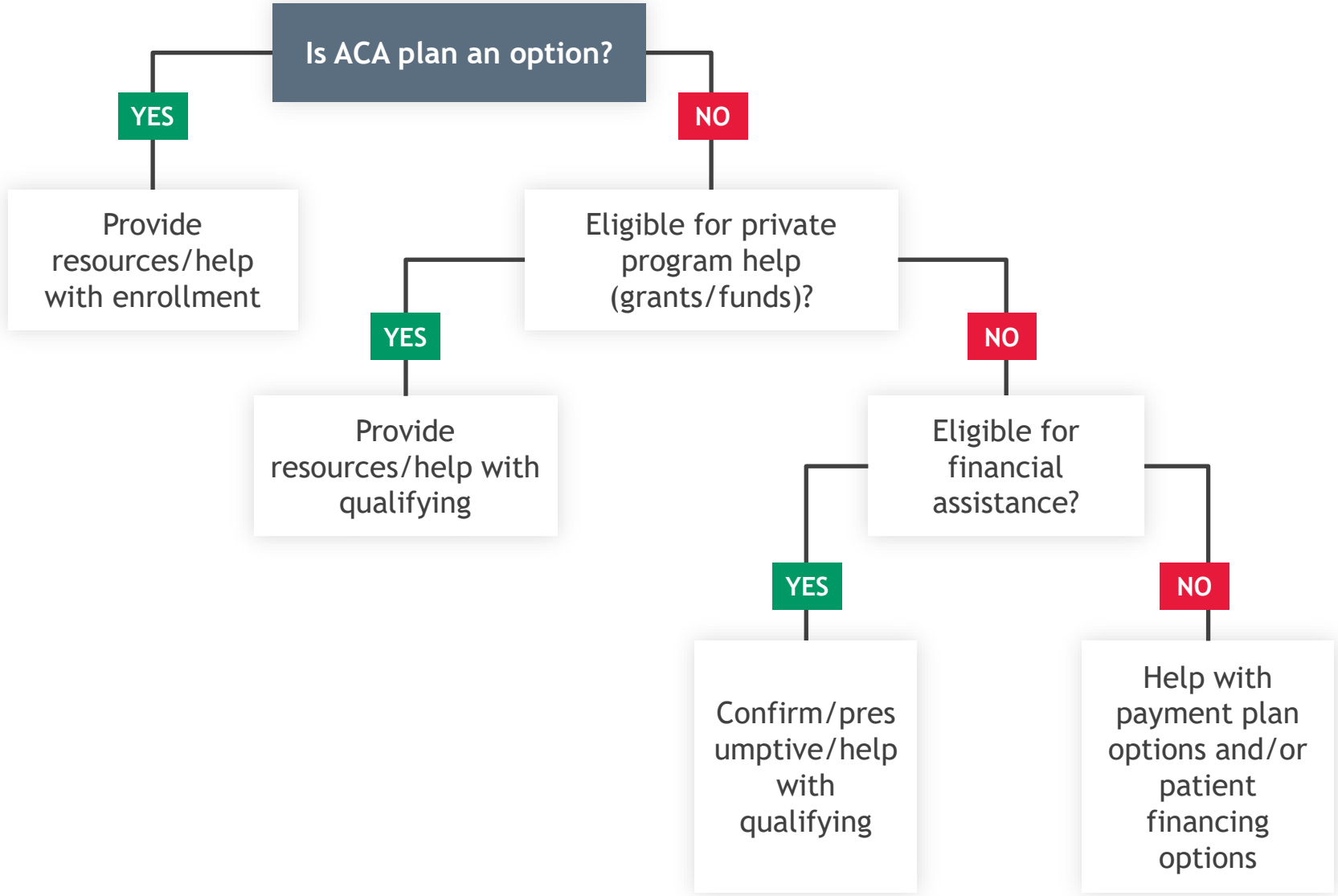
Financial Advocacy for Uninsured/ Underinsured Patients

Creating a decision tree framework is an effective way to help uninsured and underinsured patients to find effective solutions for resolving financial responsibility.



Financial Advocacy for Uninsured/ Underinsured Patients

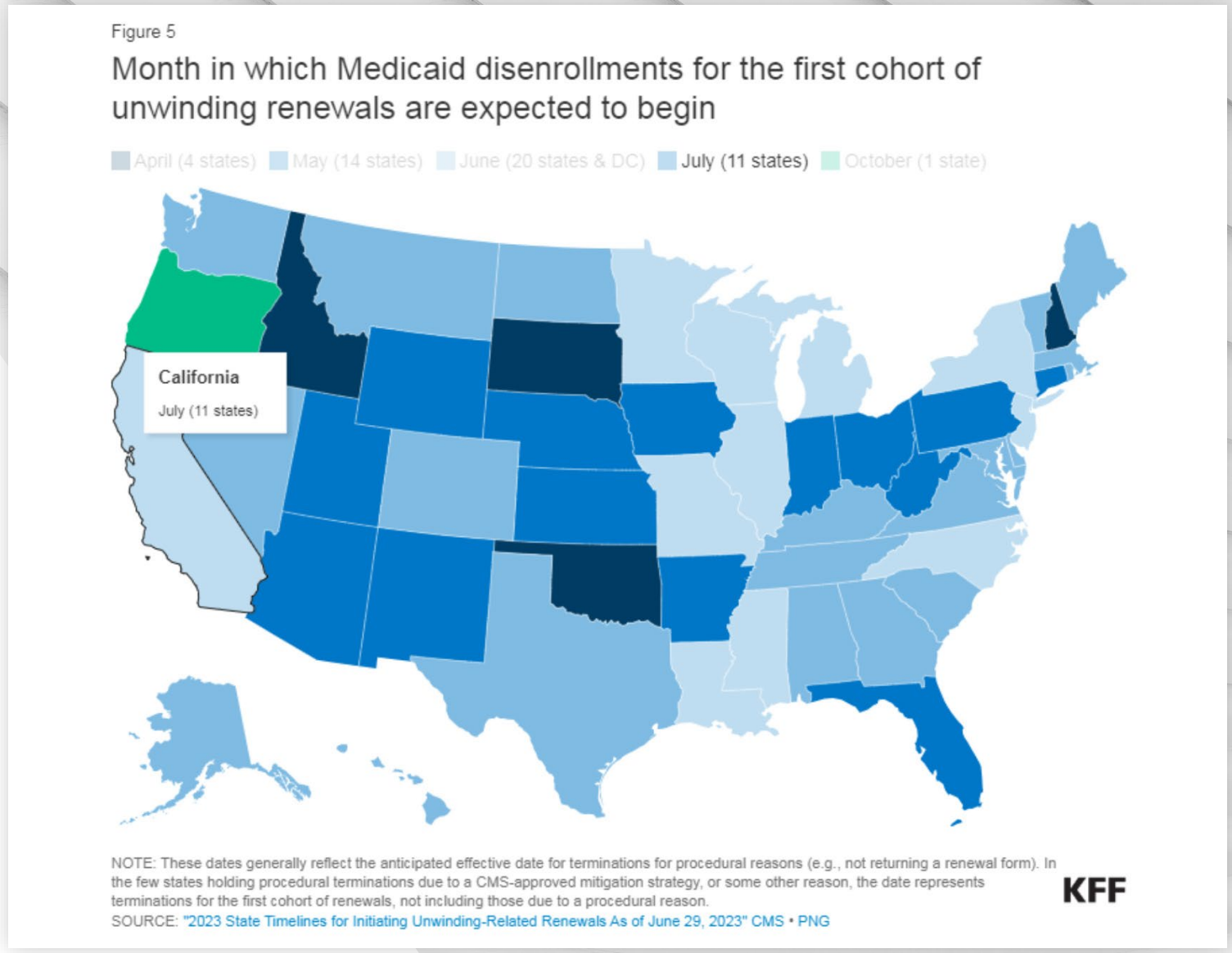
Creating a decision tree framework is an effective way to help uninsured and underinsured patients to find effective solutions for resolving financial responsibility.



Regulatory Factors: Medicaid Redetermination

Medicaid Disenrollment Background

Enrollment in Medicaid grew from an estimated 23.3 million to nearly 95 million from February 2020 to March 2023 primarily due to the continuous enrollment provision mandated under the Families First Coronavirus Response Act (FFCRA). As part of the Consolidated Appropriations Act signed into law on December 29,2022 Congress ended the continuous enrollment period on March 31, 2023.



Source: Medicaid Enrollment and Unwinding Tracker | KFF

Medicaid Disenrollment Data

At least 8.8 million Medicaid enrollees have been disenrolled as of October 16th, based on the most current data from 50 states and the District of Columbia as collected and reported by KFF.

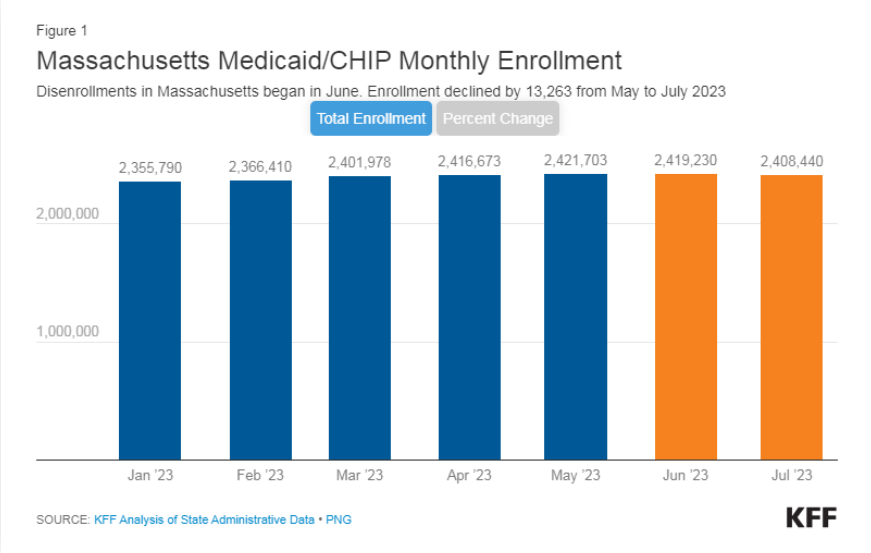
- Due to lags in state reporting, the actual number of disenrollments is undercounted in the latest KFF report
  - **35%** of completed renewals resulted in disenrollment
  - 15.9 million enrollees had coverage renewed **(65%)**
- Disenrollment rates vary widely across states reporting data from 66% in Texas to 11% in Illinois
  - Differences in who states are targeting for early renewals as well as renewal policies and system capacity are likely driving variation

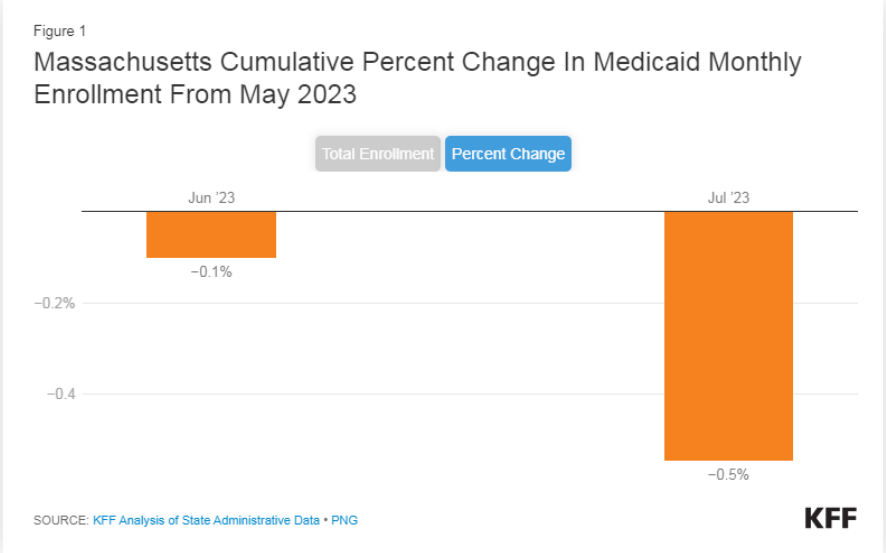
- **72%** of disenrolled recipients were terminated for procedural reasons
  - Contact information could have been out of date and recipient could not be reached to initiate renewal process
  - Some states have paused procedural terminations while they address renewal process problems
- Of the 15.9 million who had coverage renewed **56%** were renewed through ex parte processes
  - Federal rules require states to first attempt administrative ("ex parte") renewals by verifying eligibility through available data sources such as state wage databases

Source: Medicaid Enrollment and Unwinding Tracker | KFF

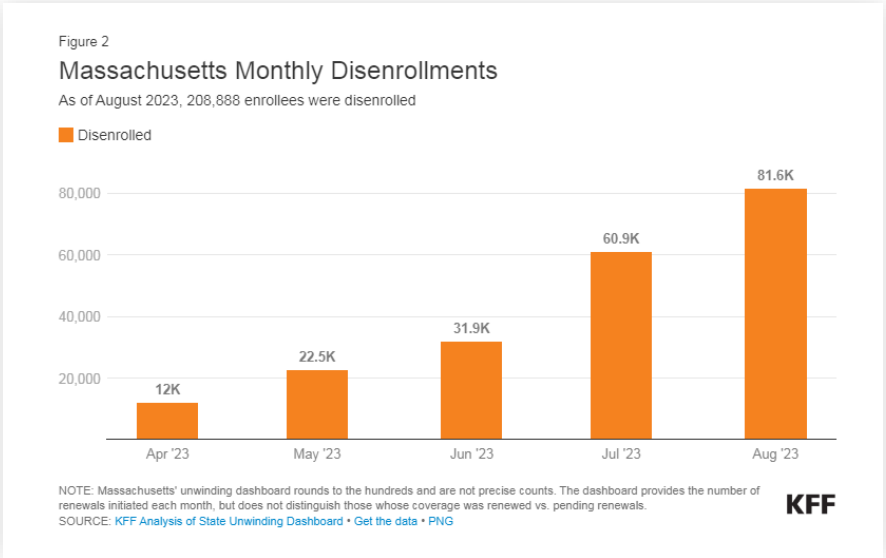
MEDICAID REDETERMINATION

Massachusetts Data





Disenrollments in Massachusetts began in June



[Source: Medicaid Enrollment and Unwinding Tracker | KFF]

Open Discussion

About BDO USA

At BDO, our purpose is helping people thrive, every day. Together, we are focused on delivering exceptional and sustainable outcomes — for our people, our clients and our communities. Across the U.S., and in over 160 countries through our global organization, BDO professionals provide assurance, tax and advisory services for a diverse range of clients.

BDO is the brand name for the BDO network and for each of the BDO Member Firms. BDO USA, P.C., a Virginia professional corporation, is the U.S. member of BDO International Limited, a UK company limited by guarantee, and forms part of the international BDO network of independent member firms.

www.bdo.com