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Survey: Health Care Providers Experience Conservative Bad Debt Recoveries

Health care and finance leaders surveyed on the state of bad debt today say it's influenced more by insurance reform than patient delinquency leading everyone to agree that there is room for improvement in revenue cycle management (RCM) processes.

A survey conducted by Baltimore-based health care research firm Sage Growth Partners found that 59 percent of 100 respondents believe insurance reform, including higher copays for patients, "is to blame" for bad debt, especially those representing smaller hospitals. The study was conducted on behalf of health care technology company Dorado Systems.

Meanwhile, 17 percent of respondents said patient delinquency is the cause of bad debt, while others said causes include "ineffective facility-specific RCM processes (11 percent), industrywide RCM complexities and regulations (10 percent), changes in reimbursement models (2 percent), and a high poverty rate (1 percent)," according to a news release from Sage Growth Partners.

Of the 11 percent of respondents citing internal RCM procedures as the main cause of bad debt, a significant majority (81 percent) were at the executive level, including CEOs, CFOs and COOs, it states.

Among leaders at smaller hospitals responding to the survey, 75 percent at hospitals with 50 to 100 beds and 68 percent at hospitals with less than 50 beds cite insurance reform as the cause for bad debt.

"Bad debt is an industrywide issue that has only grown increasingly more challenging in the last five years," Dan D'Orazio, CEO of Sage Growth Partners, said in the news release. "While external factors like insurance reform have compounded the problem, it's important for leaders to talk about this issue strategically with their teams, and to remember that there are steps they can take to mitigate bad debt."

Did You Know?

Since 2000, all hospitals have provided more than $576 billion in uncompensated care (including bad debt and financial assistance) to their patients.

Source: American Hospital Association
https://bit.ly/2MnSKuo

Bad Debt Recoveries

When it comes to collecting bad debt, 50 percent of survey respondents predict they can recover up to 10 percent from a payer or a patient, meaning many face significant write-offs.

Thirty-six percent of respondents say their bad debt is higher than $10 million, 20 percent say it's between $10-$30 million and 10 percent report bad debt between $30 and $50 million, according to the survey.

While many health care organizations face bad debt, the survey shows one in five have no third-party partner or established internal procedure to recover the dollars.

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CARE QUALITY

Is Value-Based Care Working?

Value-based care, the model that bases payments on quality of care, is starting to reduce medical costs and improve patient services, according to a recent survey from Change Healthcare conducted by ORC International.

In fact, the results show value-based care is accomplishing the "triple aim" sought after in the industry, meaning providing better care for consumers, improving population health management plans and lowering health care expenses.

According to "Finding the Value: The State of Value-Based Care in 2018," the model is reducing unnecessary medical costs 5.6 percent on average while improving care and patient engagement. Nearly 25 percent of respondents said their savings exceed 7.5 percent.

"Despite easing or ending of federal mandates, commercial lines of business are investing in value-based innovation, accelerating the decline of pure fee-for-service faster than previously projected levels. Indeed, today nearly two-thirds of payments are now based on value," according to a news release on the survey from Change Healthcare (https://bit.ly/2KcCGyS).

The survey includes 120 payers such as Managed Medicare and Managed Medicaid across multiple regions and organization sizes.

"Payers are finding the positive impact of value-based care as they scale these models—particularly episodes of care—and that's starting to bend the cost curve in a significant way," Carolyn Wukitch, senior vice president and general manager, Network and Financial Management, Change Healthcare, said in the news release. "However, the demand to innovate at the pace of change is challenging payers. They lack satisfactory analytics and automation to better engage providers, operationalize their models and assess effectiveness overall."

Additional findings from the survey include:

- Nearly 80 percent of payers say they've experienced improvements in care quality, while 64 percent report improvements in provider relationships and 73 percent report better patient engagement.
- The fee-for-service model is fading at a faster rate than predicted in previous studies, now representing just 37.2 percent of reimbursement, and projected to drop below 26 percent by 2021.
- More than half of payers surveyed, however, "are not very satisfied with their current value-based analytics, automation and reporting capabilities—despite the fact that many of these are designed and developed in-house."

Visit 2018VBCstudy.com to access the complete research report, Finding the Value: The State of Value-Based Reimbursement in 2018.

Examples of value-based care models for health care providers are available from the Centers for Medicare and Medicaid Services (http://go.cms.gov/1jxyhoF.)

HEALTH CARE COSTS

Research Shows Growth in Health Care Prices

The prices for a range of health care services are growing more rapidly than economic inflation in the U.S., according to new research published by the Kaiser Family Foundation (KFF).

The research focuses on trends in health care prices, use of services and health care spending in the U.S. versus other similar countries.

Consumers with private insurance experience particularly high increases in costs for services. The KFF also finds that there is "significant geographic variation in prices."

"For example, the average price of a full knee replacement for those in large employer plans increased from $19,595 in 2003 to $34,063 in 2016, growth of 74 percent compared to a 28 percent increase in general inflation," it reports.

In New York City, the average cost of the same knee replacement is more than double the cost in the Louisville, Ky., area.

Overall, private insurance prices for inpatient hospital services are significantly more than what is paid by Medicare and Medicaid, and the gap is increasing over time, according to the KFF.

Compared to other countries, the KFF finds that the prices in the U.S. are higher for health care and prescription medications, but use of services, such as physician visits, is lower.

And, the average health care spending per person in other comparable countries is half as much. In the U.S. the average health expenditures per person in 2016 was $10,348, compared to $7,919 in Switzerland and $5,551 in Germany.

The U.S. spent 18 percent of its GDP on health care in 2016, compared to 12 percent in Switzerland.

More information: https://kaiserf.am/2yPwrMa

PAYMENTS

How Health Care Providers Can Respond to Trends in Bad Debt, Patient Payments

Increasing out-of-pocket health care expenses, combined with increasing difficulty for patients to make payments are ongoing trends in the health care collections industry that providers and their third-party collection agency partners need to address.

Shawn Yates, director of product management for ACA International member company Ontario Systems, covers these trends in a recent article for *Bloomberg Law*.

"As this increased medical financial responsibility has fallen to patients—many of whom have mortgages, auto loans, utility bills, student loans … the list goes on—providers are finding themselves at the bottom of the priority list when it comes to settling accounts," Yates writes.

The Internal Revenue Service's requirements on reporting bad debt, changes with Medicaid funding and technology are factors providers and collection agencies need to continue to consider as they work with patients on managing their payments.

"Accounts receivables departments must be more strategic about how they collect patient balances in an effort to make the percentage of the amount collected as efficient as possible," according to Yates.

Read more insights on health care receivables from Yates on the Bloomberg Law website: https://bit.ly/2H9C2ft

Survey: Health Care Providers *cont. from page 1*

Additional key findings in the survey include:

- Twenty-one percent of respondents say they are using neither an internal process nor a third-party vendor.
- More than a third (36 percent) work with a third-party vendor for bad debt recoveries and 25 percent established an internal process while 18 percent do both.
- A majority, 82 percent, of respondents, say they check their patients' eligibility for insurance, 18 percent do not.
- And, of those who do not check patients' eligibility, 28 percent do not have an internal process or third-party vendor established for bad debt recovery.

Read more on the survey from Sage Growth Partners here: https://bit.ly/2yJKxyR

NEWS & NOTES

Providers Adopt Secure Messaging Platforms to Contact Patients

More health care providers are using mobile technology to reach patients, according to a survey from Black Book Market Research. Eighty-five percent of hospitals and 83 percent of physician practices are using secure communication systems to connect their care teams, patients and families, according to the survey. And, secure text message programs are quickly developing into the top choice to communicate information while sensitive data are protected. https://prn.to/2lCm5Gc

Register Now for Seminar on Medical Debt Collections

Irene Hoheusle, IFCCE, vice president of Collections and Education at Account Recovery Specialists in Wichita, Kan., and a Certified Instructor for many of ACA International's health care seminars, will provide tips on "Building Rockstar Health Care Collectors," Aug. 14. Register here: https://bit.ly/2HYRwaz Visit ACA's events calendar for our complete list of upcoming seminars and conferences: https://www.acainternational.org/events

We Want To Hear From You

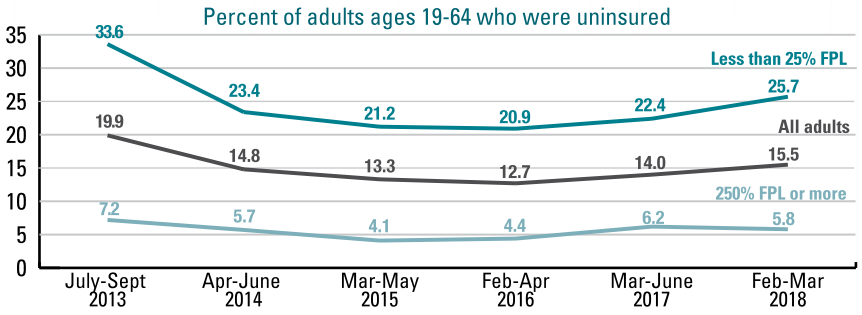
Pulse is published for ACA health care collection agencies to provide current industry information for health care providers. ACA International welcomes article ideas and submissions for consideration in *Pulse*. Ideas may be submitted to ACA's Communications Department at comm@acainternational.org.

For more health care collections news, visit ACA's Health Care Collections page at www.acainternational.org/pulse.

datawatch

Medicaid and the Uninsured Rate

The Commonwealth Fund examined the uninsured rate among working age adults (ages 19 to 64) in its latest Affordable Care Act Tracking Survey. The uninsured rate in states that expanded Medicaid remains relatively stable since 2016. At 10.4 percent in February-April 2016, it increased to 10.7 percent in March-June 2017 and to 11.4 percent in February-March 2018. *Note: FPL refers to federal poverty level; 250% FPL is about $31,150 for an individual and $61,500 for a family of four.*



Source: Sara R. Collins et al., "First Look at Health Insurance Coverage in 2018 Finds ACA Gains Beginning to Reverse: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–Mar. 2018," *To the Point* (blog), The Commonwealth Fund, May 1, 2018, http://www.commonwealthfund.org/Publications/Blog/2018/Apr/Health-Coverage-Erosion.

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