JUMPSTART

FOUNDRY

UNCOMPENSATED CARE: IDENTIFYING AND REDUCING RISK

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INTRODUCTION

Providers have traditionally collected most of their payment from payer organizations such as UnitedHealth, Anthem, or Cigna.[1] Yet more payment responsibility is shifting from payer organizations onto patients. For example, according to a report by TransUnion, patients experienced a 12% increase in their out-of-pocket responsibilities in 2018. [2] Additionally, according to another study by athena, patient obligations now account for 18% of provider revenue. [3]

This increase in patient payment responsibility is largely due to two factors. First, is the increase of consumer enrollment in high deductible health plans (HDHPs). For example, nearly 46% of private insurance members were on a HDHP in 2018, up from 25% in 2010. [4] Second, is a recent increase in the number of uninsured patients. For example, the uninsured increased from 26.7M consumers in 2016 to 27.9M consumers in 2018. [5]

When combined, the increase in enrollment in HDHPs and the uninsured results in more patients with out of pocket costs. More patients with out of pocket costs lead to higher levels of care provided that does not result in payment to the provider, known as uncompensated care. [6] For example, the payment rate for those with HDHP that have an out of pocket balance between $1,451- $5,000 is 25.5%. The payment rate drops to 10.2% for balances between $5,001-$7,500. [7] Additionally, states that expanded Medicaid access saw drops of 43% in their costs of uncompensated care, with the average hospital reducing their uncompensated care costs from $9.2M in 2011 to $5.3M in 2015. 8 In total, hospitals delivered $41.3B dollars of uncompensated care in 2018, a significant increase to the $36.1B of uncompensated care delivered in 2015. [6]

Uncompensated care comes in two forms: Charity care, also known as financial assistance, and bad debt. [6] Charity care occurs when care is given but payment is not expected. Charity care is given to those who cannot afford the cost of care. It can either be for the full cost of care or partial cost of care. The financial requirements a patient must meet to qualify for charity care varies from hospital to hospital. For example, at New York Community hospital, patients that are at or below the federal poverty level receive no charge for their care. Patients with income levels up to about 151-200% the federal poverty level pay 55% of the applicable rate. Patients at 201-250% of the federal poverty level pay 90% of the applicable rate. [9] Yet at Erlenger health system, charity care is only given to those at or below 200% of the federal poverty level. [10]

Bad debt occurs when care is given, payment is expected, but payment is not received. [6] For example, a person with a HDHP receives care for the flu at a hospital. The hospital expects the patient to pay for their care, so they send a bill to the patient. The patient receives the bill but never pays the hospital for the care delivered. The unpaid balance becomes bad debt for the hospital.

On average uncompensated care accounts for about 4.2% of total hospital operating costs. [11,12] Determining how much uncompensated care is bad debt and how much is charity care is difficult as for-profit provider organizations do not have to report their charity care to the IRS. [11] Yet a study conducted using California data, in which state

requirements mandate that all hospitals report their uncompensated care data, provides some clarity. For example, in this study of California hospitals, nonprofits' uncompensated care consisted of 43% charity care and 57% bad debt. At for-profit hospitals, uncompensated care consisted of 32% charity care, and 68% bad debt.[11]

With increasing patient self-pay responsibility and decreasing hospital operating margins, the pressure for provider organizations to reduce their uncompensated care levels is increasing.[13] To reduce uncompensated care, provider organizations have to complete two main steps: First, they need to identify who in their patient population is susceptible to producing uncompensated care. Second, they need to create patient-centric payment plans that either shift the out of pocket cost of care away from those patients or make it more manageable for them. Combined, these steps form the "Identifying and Reducing Uncompensated Care Risk" challenge for provider organizations detailed in Section 1.

Below in Section 1 is first an overview of the challenge "Identifying and Reducing Uncompensated Care Risk". Subsequently, Section 2 will review the steps provider organizations need to take to identify and reduce uncompensated care risk. The order and number of steps a provider organization must take to reduce uncompensated care risk varies based on patient insurance and financial circumstances. Therefore, this review will be done by outlining eight patient journeys that have varying insurance and payment abilities. Next, in Section 3, the startups making it easier for provider organizations to conduct the steps necessary to identify and reduce uncompensated care risk are overviewed. Finally, in Section 4, an investment recommendation for the market is made.

SECTION 1:

OVERVIEW OF THE CHALLENGE: IDENTIFYING & REDUCING UNCOMPENSATED CARE RISK

OVERVIEW OF THE CHALLENGE: IDENTIFYING AND REDUCING UNCOMPENSATED CARE RISK

To reduce uncompensated care, provider organizations first need to identify which patients have a high risk of producing it. Provider organizations can identify those at risk of producing uncompensated care in slightly different ways, yet most organizations follow a workflow similar to the one created by TransUnion that is represented below in Figure 1. [14]

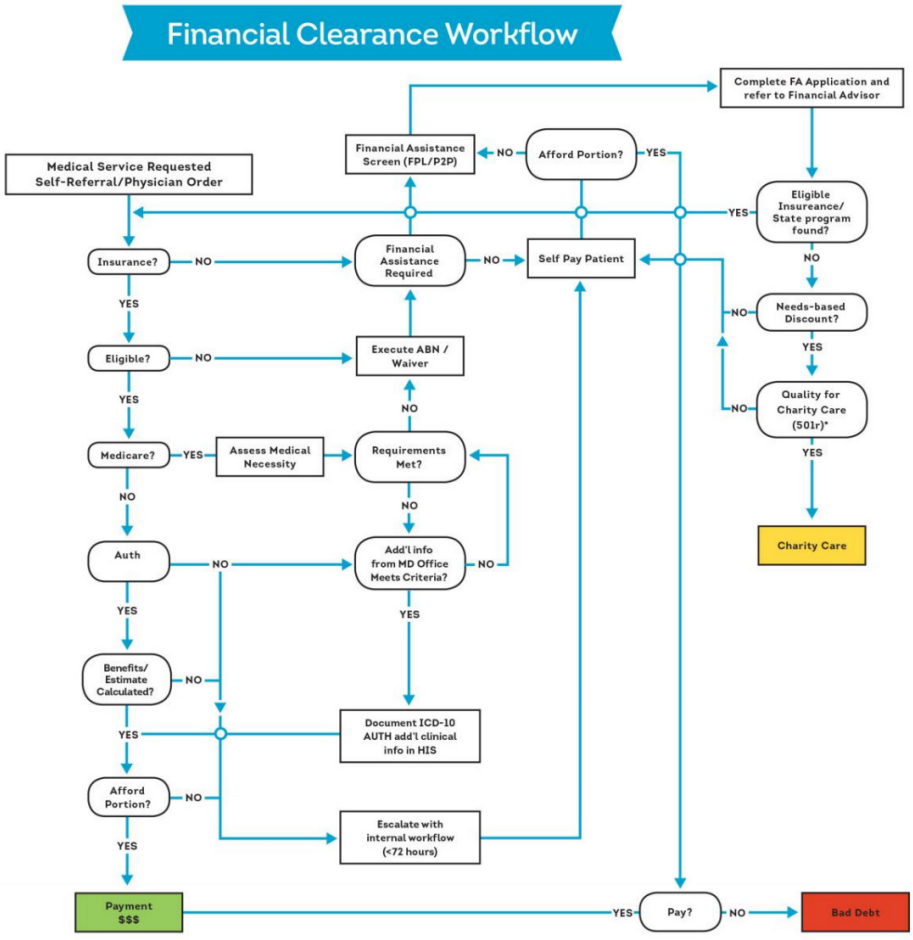

Figure 1: The various workflows a patient can go through depending on their insurance coverage and financial situation. [14]

For example, by following the above workflow, if an uninsured patient came into a provider organization for an unscheduled visit, the provider organization would be able to identify that they lack insurance and attempt to enroll them into insurance coverage before treating the patient. By working to enroll the patient into insurance coverage before providing care, the provider organization may be able to shift the cost of care away from the patient and onto a payer organization. Shifting the cost onto a payer organization eliminates most of the uncompensated care risk for the provider organization.

To provide clarity on how provider organizations can detect and reduce uncompensated care risk throughout their entire patient population, below are eight different examples of patients with various insurance and financial situations. Collectively, they demonstrate the different possible workflows shown above in Figure 1. The patients will have the following characteristics:

- Patient 1: Uninsured yet eligible for insurance
- Patient 2: Uninsured, ineligible for insurance, and qualifies for full Charity Care
- Patient 3: Uninsured, ineligible for insurance, and qualifies for discounted care
- Patient 4: Uninsured, ineligible for insurance, and does not qualify for discounted care
- Patient 5: Fully covered by insurance
- Patient 6: insured, has out of pocket costs, and qualifies for discounted care
- Patient 7: Insured, has out of pocket costs, does not qualify for discounted care, and cannot afford their out of pocket costs
- Patient 8: Insured, has out of pocket costs, does not qualify for discounted care, and can afford their out of pocket costs

During each patient journey, the main decision points in the workflow are bolded. These decision points are "sub-challenges" for provider organizations under the overarching "Identifying and Reducing Uncompensated Care Risk" challenge. These sub-challenges are:

- Conducting Insurance Eligibility Verification
- Collecting Prior Authorization
- Conducting Financial Assistance Screening
- Estimating Propensity to Pay
- Creating a Payment Plan

These sub-challenges will be explained in-depth the first time they are mentioned. For each subsequent patient journey, the sub-challenges will not be explained in-depth to reduce redundancy. The in-depth explanation of the sub-challenges will include two parts:

- How the process of alleviating the sub-challenge used to be done.
- How the process is currently being done with new technology.

Additionally, an explanation will be outlined at the end of each patient journey to provide clarity around how following the workflow reduces uncompensated care risk.

SECTION 2:

PATIENT JOURNEYS

PATIENT 1: UNINSURED YET ELIGIBLE FOR INSURANCE

Step 1: Patient 1 arrives at a provider organization for an unscheduled visit. The provider organization first needs to determine if she has insurance and what care the insurance covers. This process is called **insurance eligibility verification**. [15]

Historically, in order to run the Insurance Eligibility Verification process, front office staff at a provider organization would have to call, fax, and email payer organizations to determine if the patient was still covered under the insurance the patient gave them, what services the plan covered, and therefore what the patients possible out pocket costs would be. This manual process was time intensive.

Now, new technology is enabling provider organizations to reduce the time spent checking for insurance eligibility by enabling providers to run insurance eligibility verification in real-time. [16] For example, provider organizations will collect the patient's information, then the new tech platform will automatically search the correct payer portal and provide real-time updates on the patient's coverage. In this hypothetical example, after going through insurance eligibility verification, it is determined that Patient 1 does not have any active insurance coverage.

Step 2: After going through insurance eligibility verification, Patient 1 then undergoes Financial Assistance Screening. Financial Assistance Screening is the process in which a provider will check to see if the patient is eligible for insurance or needs reduced or fully discounted care. [17]

Historically, during Financial Assistance Screening, a financial counselor at the hospital would sit down with the patient and run a manual screen to see if the patient qualifies for insurance coverage. Then if it was determined the patient needed additional financial help, the financial counselor would manually check to see if the patient qualified for any grants that could shift some of the out of pocket costs a patient may face. [17]

Now, technology is enabling counselors to run this two-step process more quickly and accurately. For example, new technology is enabling patients to walk through financial screening themselves to see if they are eligible for insurance. Additionally, this technology is enabling provider organizations to use patient information to automatically check for various grants that the patient is eligible for by automating the manual inclusion or exclusion criteria search across all of the different grants. In this scenario, it is determined Patient 1 is eligible for Medicaid. Therefore, the provider organization will help her apply for Medicaid. [17,18]

Step 3: Next, during the patient's visit, the provider organization will conduct prior authorization. **Prior authorization** is the process in which a provider organization checks to see if the service is deemed necessary and the payer organization will reimburse for it. Prior authorization is not needed for all care services. It is mostly needed before very expensive tests or procedures are conducted. If prior authorization is needed, the provider then submits a request for authorization with clinical evidence to back up the claim the service is necessary. [19]

Historically, prior authorization has been a manual process in which a provider organization would have to manually check with the payer to see if the service needs prior authorization. Then they would have to collect patient specific information and fax it to the payer for review. This prior authorization process was a tedious and time consuming task for provider organizations. [19]

Now, through new prior authorization technology, provider organizations are able to reduce a lot of the manual checking for approval, finding specific information, and faxing the documents to the payer. Instead this entire process can be done digitally. 20 In this hypothetical situation, Patient 1 needs prior authorization for some of her care, and it is approved. The provider then bills Medicaid for her care.

How Workflow Reduced Uncompensated Care: By conducting the Financial Assistance Screening, the provider organization was able to enroll the patient in Medicaid. By enrolling the patient in Medicaid, the provider was able to shift the cost of care onto a payer organization. If they did not attempt to enroll the patient in Medicaid, they would have had to give the patient charity care if the income requirements were met.

PATIENT 2: UNINSURED, INELIGIBLE FOR INSURANCE, AND QUALIFIES FOR FULL CHARITY CARE

Step 1: Patient 2 arrives at a provider organization for an unscheduled visit. The provider organization first needs to determine if she has insurance through insurance eligibility verification. It is determined that she does not have insurance.

Step 2: She undergoes **Financial Assistance Screening** where they check for insurance eligibility. It is determined she is ineligible for Medicaid.

Step 3: After the financial assistance screening, they determine with her income level that she qualifies for full Charity Care. Charity care is given to those who cannot afford the cost of care. It can either be for the full cost of care or partial cost of care. In this hypothetical situation, Patient 2 qualifies for full Charity Care.

How Workflow Reduced Uncompensated Care: Through this process, the provider organization did not reduce the uncompensated care levels, but they did make sure to correctly give this person charity care versus it becoming bad debt. This is important as it gives the provider organizations evidence of providing charity care, which helps them maintain their tax-exempt status.

PATIENT 3: UNINSURED, INELIGIBLE FOR INSURANCE, AND QUALIFIES FOR DISCOUNTED CARE

Step 1: Patient 3 arrives at a provider organization for an unscheduled visit. The provider organization first needs to determine if she has insurance and what is covered through **insurance eligibility verification**. It is determined that she does not have insurance.

Step 2: She undergoes **Financial Assistance Screening** where they check for insurance eligibility. It is determined she is ineligible for Medicaid due to her income level. During the financial assistance screening, they determine with her income level that she qualifies for discounted care. This leaves Patient 3 with out of pocket costs.

Step 3: To determine the risk of this payment becoming bad debt in comparison to receiving payment, the provider organization determines Patient 3's Propensity to Pay. **Propensity to pay** is the determination of how likely a patient is to pay their out of pocket costs. Historically, provider organizations did not have a great way to estimate the propensity of a patient to pay. They could look at income levels and credit scores. Now, new technology is enabling providers to analyze a patient's financial history and out of pocket costs in comparison to past payment rates to more accurately assess how likely the patient is to pay. [21]

Step 4: Once the provider organization has determined the propensity to pay, they can create a **Payment Plan** for the patient before the patient leaves. Historically, providers have not had a great way to collect payment from a patient after they leave. The usual process to collect entailed mailing paper billing statements to the patient and calling the patient to collect payment. [22] Now through technology, provider organizations can onboard patients onto a platform while they are at the provider organization. [23] By onboarding the patient onto the platform, the provider organization can create and monitor a payment plan that works for the patient. For example, the patient may pay some of the cost upfront, and the rest in installments the patient can afford through the platform overtime.

How Workflow Reduced Uncompensated Care: By running the patient through a propensity to pay screening, the provider organization was able to predict risk of uncompensated care. This informed their decision to create a payment plan with the patient that fits within the patient's capabilities. This increases the likelihood the out of pocket costs will be received and uncompensated care is avoided.

PATIENT 4: UNINSURED, INELIGIBLE FOR INSURANCE, AND DOES NOT QUALIFY FOR DISCOUNTED CARE

Step 1: Patient 4 arrives at a provider organization for an unscheduled visit. The provider organization first needs to determine if she has insurance through **insurance eligibility verification**. It is determined that she does not have insurance.

Step 2: She undergoes **Financial Assistance Screening** where they check for insurance eligibility. It is determined she is ineligible for Medicaid due to her income level. During the financial assistance screening, they determine with her income level that she does not meet the financial requirements to qualify for the provider organization's discounted care either. It is determined she will have out of pocket costs and become self-pay.

Step 3: She is then put through **propensity to pay** screening and the provider organization. During the propensity to pay screening, it is determined that she has a low propensity to pay.

Step 4: The provider organization then creates a **payment plan** for her.

How Workflow Reduced Uncompensated Care: Similar to Patient 3, by running the patient through a propensity to pay and payment plan screening, the provider organization is able to create a payment plan that works for the patient. This reduces uncompensated care by enabling the patient to pay in a way that works for them. Additionally, the propensity to pay score then influences the provider's collection strategy if the patient is not adherent to the payment plan. For example, if the patient does not adhere to the plan and the remaining balance is sent to collections, the provider group can use the propensity to pay score to create the right collections strategy. For example, Patient 4 had a low propensity to pay score. Therefore, the organization may not allocate many resources towards collecting. While this does not exactly reduce uncompensated care, it does reduce the collection costs for the provider organization.

PATIENT 5: FULLY COVERED BY INSURANCE

Step 1: Patient 5 arrives at a provider organization for an unscheduled visit. The provider organization first needs to determine if she has insurance through **insurance eligibility verification**. She has commercial insurance and her deductible has been met, meaning she has no out of pocket responsibility.

Step 2: The provider then checks to see if any of the services she needs require **prior authorization**. It is determined they do not require prior authorization. The provider follows the workflow on the far-left side of Figure 1 and goes through the commercial insurer for payment and does not need to worry about collecting from Patient 5.

How Workflow Reduced Uncompensated Care: By running through insurance eligibility and the services provided not needing prior authorization nearly ensures that the payer organization will pay for the services provided as long as there are no complications in the claim submission.

PATIENT 6: INSURED, HAS OUT OF POCKET COSTS, CANNOT AFFORD COSTS, QUALIFIES FOR DISCOUNTED CARE

Step 1: Patient 6 arrives at a provider organization for an unscheduled visit. The provider organization first needs to determine if she has insurance through **insurance eligibility** verification. It is determined that she does have insurance. With her care plan, it is then determined she will have out of pocket costs.

Step 2: Patient 6's treatment plan requires the provider to check for **prior authorization** requirements.

Step 3: She then goes through a **propensity to pay** screening. It is determined she has a low propensity to pay score.

Step 4: Patient 6 then undergoes **Financial Assistance** screening because in the propensity to pay screening, it was determined she would not be able to afford the cost of care. In the Financial Assistance screening it is

determined she qualifies for discounted care. During this screening it is determined that even with the discount to her care price, Patient 6 will still have a hard time paying her out of pocket costs. At this point, the counselor helps the patient apply for grants that can further shift the cost. For example, there is an organization called HealthWell Foundation that helps insured patients with their medical bills. The counselor will help the patient apply for grants at organizations similar to HealthWell to shift the out of pocket responsibility of the patient.

Step 5: The provider organization creates a **payment plan** for the rest of the care costs.

How Workflow Reduced Uncompensated Care: By running through the above steps and helping Patient 6 apply for grants, the provider organization shifts more of the out of pocket responsibility away from the patient. This enables the provider organization to lower the patient responsibility, which lowers the uncompensated care risk. Additionally, by lowering the patient's out of pocket responsibility, the patient may become more likely to pay. For example, the patient may not attempt to pay $600 out of pocket. But if the total out of pocket cost is only $150, they may make more of an attempt to pay.

PATIENT 7: INSURED, HAS OUT OF POCKET COSTS, DOES NOT QUALIFY FOR DISCOUNTED CARE, AND CANNOT AFFORD THEIR OUT OF POCKET COSTS

Step 1: Patient 7 is scheduled to have a procedure. The provider organization first needs to determine if she has insurance and what it covers through **insurance eligibility verification**. It is determined that Patient 7 does have insurance.

Step 2: Due to the treatment plan, the provider then runs a **prior authorization** check. After understanding the payer will cover the treatment, it is determined that the patient still has out of pocket expected costs.

Step 3: The provider organization sends her through a **propensity to pay** screening where it is determined she has a low chance of paying her out of pocket costs.

Step 4: The provider organization then sends her to **Financial Assistance Screening** where she does not qualify for discounted care. Additionally, they help her apply for grants.

Step 5: The provider organization then works with the patient to create a **payment plan**.

How Workflow Reduced Uncompensated Care: Conducting prior authorization before the procedure is an important step to reduce uncompensated care. If the provider organization does not conduct prior authorization, they do not know if the procedure will be covered by the payer. If the provider conducts the procedure without checking and it is not covered, the patient then becomes responsible. If the patient becomes responsible for the cost and cannot afford it, then the cost of care would become uncompensated care.

PATIENT 8: INSURED, HAS OUT OF POCKET COSTS, DOES NOT QUALIFY FOR DISCOUNTED CARE, AND CAN AFFORD THEIR OUT OF POCKET COSTS

Step 1: Patient 8 is scheduled to have a procedure. The provider organization first needs to determine if she has insurance and what it covers through **insurance eligibility verification**. It is determined that Patient 7 does have insurance.

Step 2: Due to the treatment plan, the provider then runs a **prior authorization** check. After understanding the payer will cover the treatment, it is determined that the patient still has out of pocket expected costs.

Step 3: The provider organization sends her through a **propensity to pay** screening where it is determined she has a high chance of paying.

Step 4: The provider organization then works with the patient to create a **payment plan**. In this circumstance, they ask Patient 8 to pay her costs before leaving, and she does.

How Workflow Reduced Uncompensated Care: By working through the workflow above, the provider organization was able to collect payment for care before the patient left. This eliminated the risk that the patient resulted in uncompensated care.

SECTION 3:

STARTUPS WORKING ON SUB-CHALLENGES WITHIN "IDENTIFYING AND REDUCING UNCOMPENSATED CARE RISK"

STARTUPS WORKING ON SUB-CHALLENGES WITHIN "SORTING THE PATIENT POPULATION INTO PAYMENT WORKFLOWS"

Insurance Eligibility Verification Startups

- Availity - Availity allows for providers to establish real-time eligibility (RTE) to determine what a patient's insurance covers.
- Pokitdok (acquired by Change) - Pokitdok allows providers to conduct real-time insurance benefits verification for over 93% of the insured population.
- Eligible - Eligible enables providers to quickly check for insurance benefits and submit and track claims.
- HealthiPass: HealthiPass provides a check in system for patients that conducts insurance eligibility verification and enables up-front payment
- WayStar - Waystar enables providers to quickly check for insurance benefit eligibility and enables providers to create payment plans by alerting them of deductible and copay patient obligations.
- Cleargage - Cleargage has created a platform that allows patients to understand their portion of care costs upfront and enroll in a provider approved payment plan.

Prior Authorization

- Verata Health - Verata Health is automating prior authorization by attaching to practice EMRs and following prior authorization to completion without human oversight.
- PriorAuthNow - PriorAuthNow is digitizing the prior authorization process for providers and enabling them to receive real time authorization updates.
- Glidian - Glidian enables providers to submit all prior authorizations electronically and allows providers to receive real time alerts when authorization comes through.
- Olive - Olive is using robotic process automation (RPA) that verifies the need for prior authorization and will continually check for authorization

Propensity to Pay

- Sift Health - Sift Health uses data to create propensity to pay models that enables physicians to understand who will pay and how to best collect from those patients.
- Simplee (acquired by Flywire) - Simplee creates customized payment plans for each patient based off their current financial situation.
- TransUnion - TransUnion has created a propensity to pay tool that enables providers to determine how much a patient can most likely pay out of pocket.
- Experian Health - Experian Health has created the "Collections Optimization Manager" that enables hospitals to determine who is likely to pay so that hospitals can most effectively deploy their resources to collect those funds.
- Health Catalyst - Health Catalyst has built a suite of products, one of which enables provider organizations to build algorithms with numerous variables to determine propensity to pay.

Payment Plan

- HealthiPass - HealthiPass provides a check in system for patients that conducts insurance eligibility verification and enables up-front payment by keeping a card on file for the practice.
- Ooda Health - Ooda Health is realigning providers, payers, and consumers, enabling providers to get paid upfront through the payer.
- Rivet Health - Rivet Health has created a solution that maximizes provider payment from payers and consumers by detecting underpayment from payers and enabling upfront and transparent payment from patients.
- Cedar - Cedar offers a billing platform that allows patients to see what they were billed for, how much they owe, and enables them to quickly pay through the Cedar app.

SECTION 4:

INVESTMENT RECOMMENDATION: BUY

INVESTMENT RECOMMENDATION: BUY

There is investment opportunity in each sub-challenge within the larger "Identifying Uncompensated Care Risk" challenge. Organizations with larger budgets could pay for systems that address all of the sub-challenges outlined above. Some organizations may only have budgets to digitize their most pressing problem. The most pressing problem will vary across organizations. Interestingly though, according to a report by InstaMed, 87% of providers still leverage paper and manual processes for collection. [24] Organizations that enable more seamless collections from patients once they leave is an area still under addressed. Not only can these platforms be used as a way to get patients to pay their self-pay costs, these platforms could also be used as marketing channels to keep patients in a provider organization's system.

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