

Analytic Trends Show Changing Landscape of Hospital Self-Pay Patient Collections

Crowe[®] RCA Benchmarking Analysis: April-June 2015

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Executive Summary

As more of the financial responsibility shifts from insurer to the patient due to increased market preferences for high-deductible health plans (HDHP), and as populations move from uninsured self-pay to insured following the enactment of the *Affordable Care Act* (ACA), provider focus on patient collections for insured self-pay copays and deductibles is becoming a greater priority.

When looking at changes in revenue cycle metrics associated with the 14.1 million¹ newly insured patients since the enactment of the ACA in October 2013, overall provider collections have improved and a portion of revenue has shifted to a more reliable payer source from previously uninsured self-pay patient responsibility. This source is likely Medicaid – or managed Medicaid, for those patients with an income between 100 percent and 138 percent of the federal poverty level – and originates primarily in Medicaid expansion states.

Other newly insured patients have enrolled in the healthcare marketplace exchanges. On average, 85 percent² have selected Bronze and Silver HDHPs. Providers will be challenged to manage collections from this new patient group that might not be accustomed to navigating the complex world of health insurance ownership. Also, with the industry shift toward consumer-driven healthcare, many patients that already were insured are selecting – or their employers are moving away from – traditional health plans with lower patient responsibility for HDHPs. These two market trends have resulted in higher overall and average patient responsibility for insured patients.

In this new environment, overall financial risk has moved away from the uninsured self-pay payer group to the insured self-pay in the form of patient copays and deductibles, mostly from HDHPs. For the purposes of this report, these two patient populations are defined as follows:

1. Insured Self-Pay – patient responsibility for accounts with an insurance payer source (copays and deductibles)
2. Uninsured Self-Pay – patient responsibility where self-pay is the primary payer

The table below, “Self-Pay Patient Collections – Key Performance Metrics,” illustrates the contrasting trends of the insured self-pay and uninsured self-pay patient collection categories.

Overall financial risk has moved away from the uninsured self-pay payer group to the insured self-pay in the form of patient copays and deductibles, mostly from HDHPs.

- + Favorable Increase
- Favorable Decrease
- + Unfavorable Increase
- Unfavorable Decrease

Patient Collections – Key Performance Metrics

Self-Pay Patient Collections Group	Average POS Payment (\$)³ Q1 2014 vs. Q1 2015	Average Non-POS Payment (\$)⁴ Q1 2014 vs. Q1 2015	Percentage A/R > 180 Days (\$)⁵ June 2014 vs. June 2015	A/R Total A/R (\$)⁶ June 2014 vs. June 2015
Insured Self-Pay Patients	NO CHANGE	NO CHANGE	+2%	+13%
Uninsured Self-Pay Patients	+16%	-8%	-11%	-22%

A variety of metrics were compared. These metrics included patient payment amounts, rates, and volume, and also accounts receivable (A/R) data from the Crowe® Revenue Cycle Analytics (Crowe RCA) benchmarking platform, which incorporates validated daily transactional data from 444 hospitals. Data comparisons for A/R are based on month-end figures between June 2014 and June 2015, and quarterly comparisons for patient payments and volume are based on dates of service in 2014 and 2015. Metrics with significant variances between the two populations were in the areas of average point of service (POS) and non-point of service (non-POS) payment amounts, as well as overall A/R and agings. In this report, POS payments are defined as patient payments received pre-service or within four days of discharge.

Throughout each analysis, the difference between the insured self-pay and uninsured self-pay patient population groups portray a contrasting story or trend. Average total patient revenue collected for insured self-pay patients increased only slightly in Q1 2015 from Q1 2014 despite the growth in volume and patient responsibility amounts. Insured self-pay patient dollars now account for a greater percentage of providers' total A/R, and the percentage of A/R aged beyond 180 days also have been increasing. On the other hand, both the percentage of paying patients and average amount of POS payments have remained flat despite an increase in admit volume of 5 percent.

Conversely, the uninsured self-pay patient population as a group has improved in many aspects – including higher average POS payment amounts and reductions in both the percentage of total A/R as well as A/R aged beyond 180 days. These changes have occurred while the percentage of patients making payments – for both payment types – has remained steady.

Although the two groups showed a discrepancy in average non-POS payment amounts for the Q1 2014 and Q1 2015 comparison, the lack of any gain for insured self-pay patients had a greater impact on total cash collection than the 8 percent decrease for uninsured self-pay patients. Consider that for every one uninsured self-pay patient payment dollar in Q1 2015, there were approximately 22 insured self-pay patient payment dollars; therefore, insured self-pay payments have a much greater effect on total patient collections.

Understanding the performance of self-pay patient collections for both insured self-pay and uninsured self-pay patient types is a critical component of a provider's financial success. While the uninsured self-pay patient population appears to be performing better from an A/R perspective, the expanding insured self-pay patient volume and A/R highlights the need for providers to focus on this area of growing financial risk. Lower average payments from the insured self-pay population weigh more heavily than uninsured payments on an organization's bottom line. Benchmarking self-pay patient collection performance versus similar hospitals can provide additional insight into areas of opportunity and can be used to drive provider patient collection strategies.

Organizations can benchmark self-pay patient collections to similar hospitals in order to assess performance and identify opportunities to improve patient collection strategies.

Growing Financial Risk From Insured Self-Pay Patients

The average amount collected from insured self-pay patients increased marginally quarter over quarter from Q1 2014 to Q1 2015. For both POS and non-POS payment types, the percentage of patients making a payment has remained the same. Even as average patient payment amounts increased slightly, insured self-pay A/R as a percentage of total A/R and insured self-pay A/R aged over 180 days increased. Surprisingly, the data does not show increases in write-offs to uncompensated care for these unpaid patient dollars: the bad debt and charity rates have remained fairly constant at about 1 percent each. However, some providers are expecting higher uncompensated care write-offs toward the end of calendar year 2016.

Stabilizing POS Payments

Average POS payment amounts had been increasing at a nominal rate and now appear to have plateaued. Prior to Q1 2015, the quarterly average increase in POS payments was \$3 (2 percent), from 2013 to 2014, while the percentage of paying patients remained flat. However, a comparison of Q1 2014 and Q1 2015 showed no change. Quarter over quarter comparisons are required for trending purposes due to the seasonal nature of patient responsibility after insurance and resulting patient payments, with the first quarter of the calendar year being the highest of all quarterly averages. Average POS payment increases could possibly continue as the insured self-pay commercial/managed care plan mix shifts even more toward HDHPs. For more information on the growth in high-deductible health plans, please refer to the Crowe RCA benchmarking analysis report [“The New Reality: Increasing Hospital Financial Risk from Insured Patients.”](#)

In the months to come, the market may drive up POS payment averages as more employers eliminate platinum plans to avoid the “Cadillac Tax” and patients elect or are forced to switch to plans with higher deductible and copay amounts.

Stabilizing Non-POS Payments

The average amount of payments made more than four days, but within 90 days, after the date of service remained constant from Q1 2014 to Q1 2015 at \$235. The prior three quarters increased on average 4 percent (or \$7).

Trends in Accounts Receivable

The percentage of insured self-pay patient A/R increased by 13 percent from June 2014 to June 2015, as more patients were covered under insurance and the aforementioned commercial/managed care plan mix shifted toward HDHPs. The percentage of self-pay insurance A/R aged beyond 180 days increased by 2 percent for the same time period. Another increase was in the average account balance, a 1 percent increase to \$654 in June 2015.

**INSURED
SELF-PAY**
Percent A/R >
180 DAYS
↑ 2%
**JUNE 2014
THROUGH
JUNE 2015**

Change in Percentage of Total A/R (\$)

Payer Group	June 2014	June 2015	Variance
Insured A/R Dollars	73%	77%	4%
Insured Self-Pay Patient A/R Dollars	8%	9%	1%
Uninsured Self-Pay Patient A/R Dollars	19%	14%	-5%
Total	100%	100%	0%

Percentages have been rounded to the nearest whole number.

Recommendations

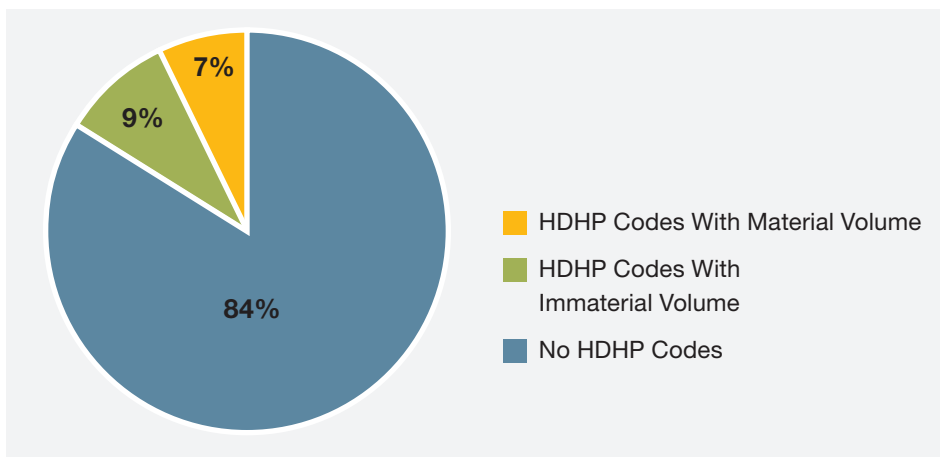
The healthcare market's transfer of financial responsibility from the insurer to the patient is a trend that is likely to continue. Providers already are seeing the impact of this dynamic through increased A/R and deteriorating agings for patient responsibility after insurance. In this new environment, it's critical for organizations to create effective strategies to improve financial performance in this area.

Providers should create unique HDHP codes to differentiate commercial/managed care payer volume into two categories:

1. Traditional: lower copays/deductibles
2. HDHP: high deductibles that can soar to more than \$5,000 for a single adult

Our analysis has revealed that only 16 percent of providers are creating these unique HDHP codes and the majority of providers that create unique HDHP codes are not effectively registering patients into these newly created plan codes. Pre-registration and registration staff need be trained to effectively identify these HDHP patients.

Hospital HDHP Code Creation and Usage



Patient access staff responsible for financial discussions should be well versed on HDHP plan types and equipped to determine which patients have the ability to pay. Processes should be in place to qualify HDHP patients who do not have the ability to pay into financial assistance programs. For all HDHP patients, options such as payment plans and prompt-pay discounts – as well as deposit requirements for elective services – should be considered.

The creation and effective implementation of HDHP codes also enables much-needed financial analysis. It is critical for providers to understand the financial impact of different plan types and plan mix changes, separating traditional and HDHP patient populations at both financial classification and payer-specific levels. This analysis should be used in financial modeling, organization projections, and also at the detailed payer level in contract negotiations.

Patient access staff responsible for financial discussions should be well versed on HDHP patients and equipped to determine patients who have the ability to pay.

Only 7% of assessed facilities showed material use of HDHP codes, and 84% of facilities had yet to create specific HDHP codes in their patient accounting systems.

Reduced Uninsured A/R and Agings

Large shifts were observed in average uninsured self-pay patient payments when comparing Q1 2014 to Q1 2015. Patients remaining uninsured have showed average POS payment amounts increasing 16 percent while non-POS average patient payment amounts decreased 8 percent. Even as average non-POS payment amounts shrink, overall uninsured self-pay A/R has dropped. Additionally, there was a drop of over 11 percent in A/R aged more than 180 days. Our analysis revealed that the timing for uninsured patient payments has accelerated. This could be related to a demographic population shift as “high financial risk” patients (those between 100 percent and 138 percent of the federal poverty level) joined Medicaid in expansion states – meaning the average patient remaining in the uninsured self-pay population group is more likely to fulfill his or her financial obligations and also is more likely to pay for those services upfront in the form of POS payments.

Increasing POS Payments

Average uninsured self-pay POS payment amounts have been steadily increasing over the past year at a quarterly average of \$51 (18 percent). The largest gain occurred when comparing the second quarters of 2013 and 2014, when the average increased \$85 from \$294 to \$379, respectively.

The increase in average POS payments for uninsured self-pay patients is being affected by both patient mix and service type. When one considers the percentage of patients making a POS payment, the likelihood greatly increases for service lines that tend to be more elective-based episodes of care, such as surgery. Although the percentage of surgery patients making a POS payment increased 21% from 2013 to 2014, the rates for emergency and inpatient service lines remained flat.

Decreasing Non-POS Payments

Differing from the flat trend in insured self-pay population, average non-POS payments decreased from Q1 2014 to Q1 2015 after the three previous quarter comparisons increased by about 24% (or \$86). The June 2015 average was \$345 – a \$31 decrease (8 percent) from the same quarter in 2014.

Trends in Accounts Receivable

Uninsured A/R as a percentage of total A/R decreased 22 percent from June 2014 to June 2015, which was expected as more patients acquire health insurance. More noteworthy, the percentage of older outstanding accounts has been shrinking. From June 2014 to June 2015, the percentage of uninsured A/R aged over 180 days fell by 11 percent. If the pool of older outstanding dollars is decreasing, does this mean that more dollars are written off to uncompensated care? The trend is the opposite, as the percentage of dollars written off to uncompensated care has decreased from 78 percent to 68 percent from Q1 2014 to Q1 2015.



Percentage of Total A/R Dollars

Uninsured Self-Pay Patient A/R Dollars	June 2014	June 2015	Variance
Expansion States	14%	8%	6%
Nonexpansion States	22%	21%	1%

Percentages have been rounded to the nearest whole number.

Diving further into the uninsured self-pay A/R analysis with a comparison of June 2014 and June 2015, a distinct difference exists between states that chose to expand Medicaid and those that did not. Nonexpansion states' percentage of uninsured self-pay A/R was greater than their expansion counterparts, and the gap is widening. In June 2014, nonexpansion states' uninsured self-pay A/R percentage was 22 percent – 8 percentage points more than expansion states' percentage. As of June 2015, the gap had grown to 13 percentage points.

Conclusion

POS payments have become a greater percentage of total collected patient dollars, with average non-POS payments remaining constant for insured self-pay patients and declining for uninsured self-pay patients. Uninsured self-pay patient A/R and agings greater than 180 days have both shown improvement through the shifting of “high financial risk patients” to other payer categories – mostly in Medicaid expansion states. Conversely, insured self-pay patient A/R and agings greater than 180 days are increasing, demonstrating the growing financial risk from insured self-pay patient responsibility.

Organizations should track self-pay patient collections, as the performance varies for uninsured and insured patient sources. Through the combined analysis of patient responsibility amounts from the EDI 835 electronic payer remittance data and the financial resolution statistics from patient accounting system data, facilities can better identify opportunities to collect insured patient copays and deductibles. In addition, benchmarking provider self-pay patient collections to similar organizations will provide additional insight into performance and identify areas of opportunity to drive organizational strategies and improve financial performance.

In addition to benchmarking, organizations can implement strategies specifically designed for the insured self-pay patient type. Organizations should use a more focused approach.

- By creating and enforcing appropriate usage of HDHP-specific codes by front-end staff, facilities can create specific work lists for pre-service and time-of-service staff as well as improve performance reporting on plans with higher write-off risk.
- Organizations should begin to better utilize plan-specific uncompensated care data in payer contract negotiations.
- Facilities should establish and enforce policies that improve collections based on pre-service deposits for elective procedures and by providing payment options for patients who are unable to pay initial balances in full.

Insured self-pay patient A/R and agings greater than 180 days are increasing, demonstrating the growing financial risk from insured self-pay patient responsibility.

Market Trends: Payer Mix

- Medicaid managed care saw the largest shift in Medicaid expansion states. It increased approximately 2.4 percentage points, from 8.6 percent in second-quarter 2014 to 11.0 percent in second-quarter 2015. The shift was comparatively much smaller in nonexpansion states, showing a 1.1 percentage point increase compared with second-quarter 2014.
- These findings are consistent with the increased market appetite to shift Medicaid administration from the traditional government setting to a managed care setting.
- Another payer group showing deviation between Medicaid expansion and nonexpansion is the commercial/managed care payer group. It saw a decline in expansion states of about 0.8 percentage points, from 31.8 percent in second-quarter 2014 to 31.0 percent in second-quarter 2015; nonexpansion states saw nearly no change in the commercial/managed care payer group.

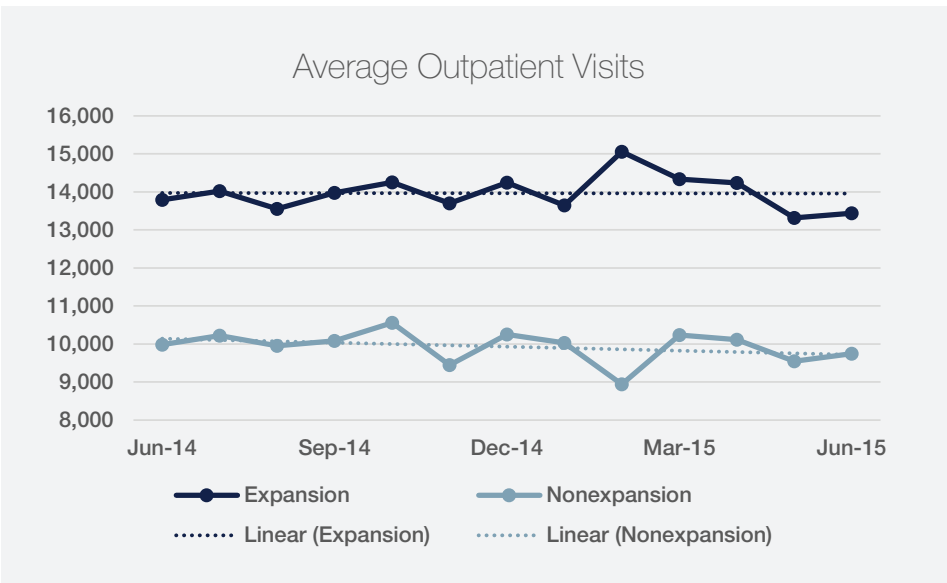
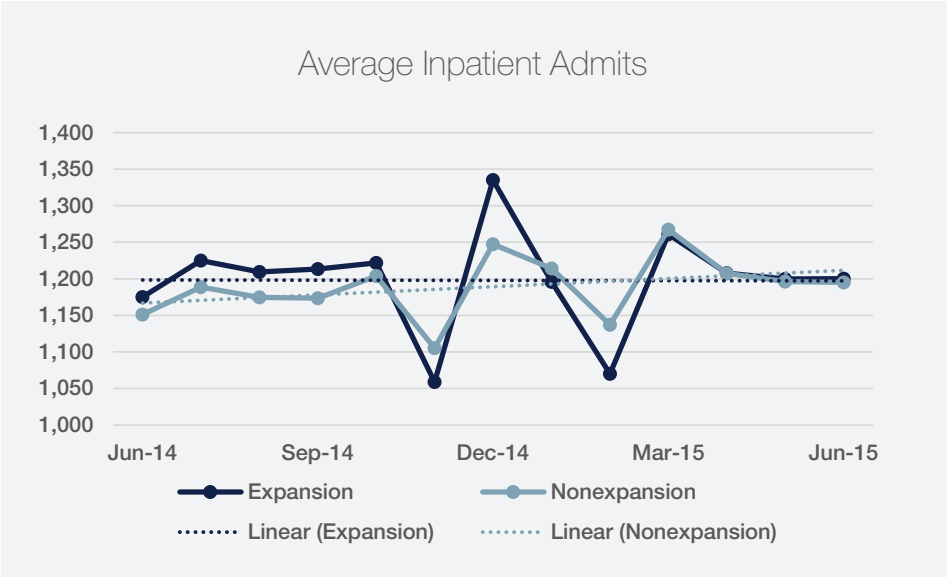
*In Medicaid expansion states, Medicaid managed care plans increased **2.4 percentage points** when comparing gross patient service revenue in second-quarter 2014 to 2015. However, this growth was slower than the first-quarter 2014 to 2015 growth of 4.5 percentage points.*

Payer Mix	Medicaid Expansion			Nonexpansion		
Payer Group	6/30/14	6/30/15	Change	6/30/14	6/30/15	Change
Commercial/Managed Care	31.84%	31.01%	-0.83%	32.61%	32.65%	0.05%
Medicaid – Managed Care	8.64%	11.02%	2.38%	7.68%	8.77%	1.10%
Medicaid – Traditional	8.23%	6.74%	-1.49%	5.39%	4.46%	-0.93%
Medicare – Managed Care	11.89%	12.10%	0.21%	11.17%	11.89%	0.72%
Medicare – Traditional	30.99%	31.40%	0.41%	31.90%	30.91%	-0.98%
Other	4.14%	4.36%	0.22%	2.85%	3.01%	0.16%
Self-Pay	4.26%	3.37%	-0.89%	8.41%	8.30%	-0.11%
Total	100%	100%		100%	100%	

Market Trends: Volume

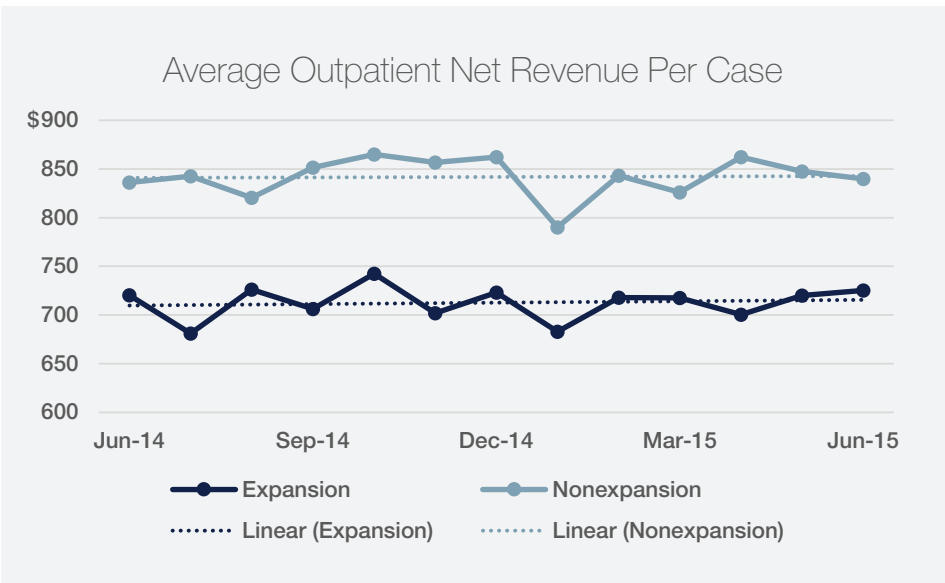
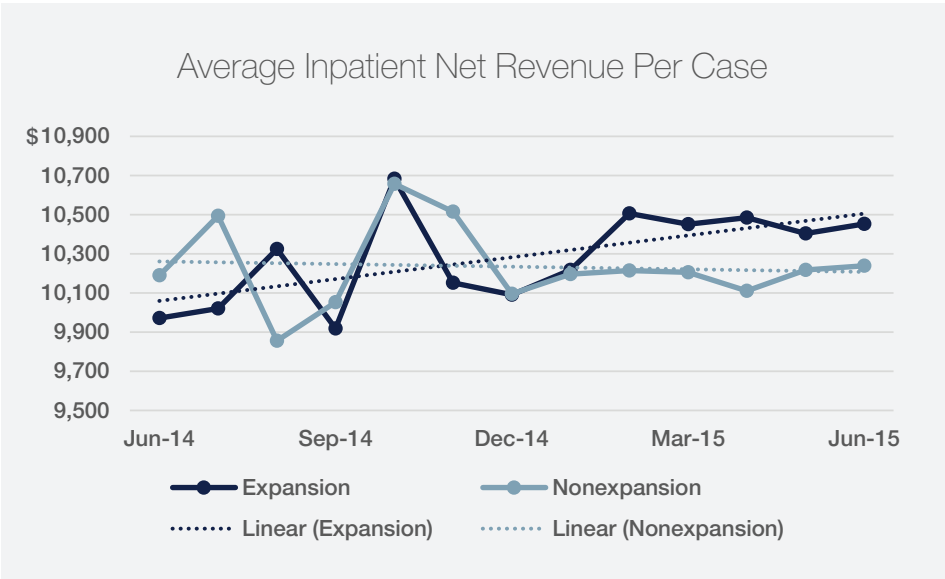
- From June 2014 to June 2015, inpatient admissions remained relatively flat for both expansion and nonexpansion states.
- Outpatient visits continued to show a sizable variance between Medicaid expansion and nonexpansion states. Medicaid expansion states had 39.2 percent more outpatient visits when compared to nonexpansion states in the second-quarter 2015. This could be caused by increased usage from the newly insured patient population.

Medicaid expansion states had **39.2%** more outpatient visits when compared to nonexpansion states.



Market Trends: Net Revenue Per Case

- Compared with June 2014, inpatient net revenue per case in Medicaid expansion states increased 7.3 percent while nonexpansion states remained relatively flat.
- Outpatient net revenue per case trended similarly to inpatient net revenue per case with a 4.1 percent increase in Medicaid expansion states while nonexpansion states remained relatively flat.
- In the second-quarter 2015, 49.0% of outpatient visits in expansion state hospitals had net revenue less than \$400 per visit, compared to 33.9% for non-expansion states. This indicates that patients in expansion state facilities are using the hospital more frequently for less intensive outpatient care.



Methodology Overview

The Crowe RCA benchmarking initiative comprised 444 distinct hospitals in a database as of August 2015. Of those, 269 are classified as acute care facilities, 65 are classified as critical-access facilities, and the remaining 110 are classified as rehabilitation, psychiatric, or cardiovascular clinics. Regarding bed counts, 167 facilities have 25 or fewer beds, 125 have 26-150 beds, 77 have 151-300 beds, and 75 have more than 300 beds. For the market-level analysis presented in this report, we considered 175 facilities – 87 in expansion states and 88 in non-expansion states. All had 125 or more beds. The hospitals with 124 or fewer beds contained a significant number of highly specialized facilities that introduced an undesirable level of inconsistency to the data distribution.

The database has information from hospitals in 37 states. The following states are represented by 20 or more facilities apiece: Colorado, Florida, Indiana, Kansas, Kentucky, Ohio, South Dakota, Texas, and Wisconsin. The database also has fields in which Crowe can customize specific peer groups to analyze hospitals in the most meaningful segments, including geographic regions, urban versus rural, academic hospitals only, outsourced versus internal revenue cycle functions, patient accounting systems, net revenue per day, and payer mix. Our method uses daily feeds of account transaction information and is supplemented by a monthly upload used for generating a variety of finance and revenue cycle metrics.

Contact Information

For more information on the Crowe RCA benchmarking program, visit crowehorwath.com/benchmarking or please contact:

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- ¹ Office of the Assistant Secretary for Planning and Evaluation (ASPE) analysis of Gallup-Healthways Well-Being Index survey data through 3/4/2015
- ² "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period," ASPE Issue Brief, May 1, 2014, http://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/apr2014/ib_2014apr_enrollment.pdf
- ³ Comparison of Q1 2014 and Q1 2015 patient payments received before or within four days after date of discharge
- ⁴ Comparison of Q1 2014 and Q1 2015 patient payments received between 5 and 90 days after date of service
- ⁵ Comparison of June 2014 and June 2015 A/R of a self-pay patient collections group aged more than 180 days divided by total A/R for a patient collections group
- ⁶ Comparison of June 2014 and June 2015 A/R of a self-pay patient collections group divided by total A/R for all payers

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The Crowe Revenue Cycle Analytics (Crowe RCA) solution was invented by Derek Bang of Crowe Horwath LLP. The Crowe RCA solution is covered by U.S. Patent number 8,301,519.

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