From Patient-to-Payment,℠ nThrive empowers health care for every one in every community.℠

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Webinar
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Best Practices for an Effective Bad Debt Program

Support optimal revenue cycle performance with a holistic approach designed to enhance bad debt recovery as well as the patient experience

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Today's Presenters

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Director, Revenue Cycle Solutions
nThrive

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nThrive

Objectives for Today

Understand market trends

for increased risk of medical debt, uncompensated care and rising collection costs

Examine strategies to increase payments

and decrease patient objections through education and guidance that result in understanding of patient financial responsibilities

Understanding compliance

and the impact on bad debt best practices

Discover how propensity to pay can help

accelerate your reimbursement and improve cash flow

Effectively resolving patient accounts is increasingly critical to providers' bottom line

Patient Access

31%

of self-pay revenue written off to bad debt actually meets **charity-eligibility guidelines**[1]

20%

once the patient leaves the hospital, likelihood of collecting drops 20% every 3 months[1]

Billing and Collections

42.9M Americans have a bill in collections

Patients satisfied with the billing process are **5x** **more likely to recommend a hospital**

-30%

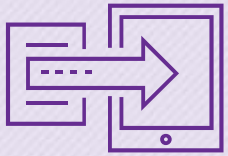
Patient satisfaction rates drop by 30%+ from post-discharge through the billing process

81%

of patients report **anger and frustration with medical bills,** which negatively impacts patient experience[2]

1 Healthcare Economics v25, Modern Healthcare: The consumer is wielding greater power, but hospitals aren't ready, CEOs say, December 22, 2017 2 nThrive focus groups

Market Forces Contributing To Bad Debt

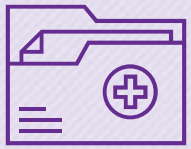


Disparate Systems

Mergers or new system implementations like EHR upgrades, require data to be merged from disparate systems to one centralized system [1]

System Backlogged

A common result is that A/R systems become backlogged [2]



Inefficiencies

The AMA estimates claims processing inefficiencies cost between $21B and $210B

High Deductibles

State insurance marketplaces and high deductible health plans created additional variation and complexity in insurance plans [3]

Decrease Costs

Health systems must find new ways to decrease costs, as private payors and employers can no longer absorb shifted costs

Strategies include lowering cost to collect and bad debt write offs, and increasing cash collections

Common Client Problems When Outsourcing to a Partner

Patient Satisfaction systems and processes

RESULTS IN
Increased cost to collect, time to resolution, write-offs

Lack of performance insight

RESULTS IN
Poor performance, quality is key to realized revenue, patient complaints impact satisfaction scores and overall experience

Compliance support for process improvement

RESULTS IN
Increased patient complaints create patient dissatisfaction. Compliance violations can result in 501R status being revoked and or fines

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The connected patient is a consumer who demands to be at the center of services

Self-service

74% of U.S. consumers are more likely to choose a health care provider that offers self- service channel flexibility.

Shop for services

15% of total health care spend ($80.8B) is out- of-pocket. 3% ($2.4B) of that was spent on consumer activity.

Access to data

52% of consumers would like to evaluate quality and satisfaction with specific providers and hospitals. 28% change providers based on availability of quality and cost data.

BEST PRACTICES

Drive Improved Patient Satisfaction in Multiple Ways

One-call resolution

- Patient education

Compassionate payment plans

- Multiple payment mechanisms
- Bilingual staff available during extended hours

Technology

- Patient portal
- External quality monitoring
- Insurance eligibility scrub upon placement
- SOC II Certification

Build the right strategy for effective account resolution

Typical gaps in the revenue cycle

Registration — Lack of financial clearance function — Care Delivery — Billing — Inadequate resources — Collections

- Registration
- Lack of errors available coverage authorization
- Lack of
- Missed reimbursement
- Likelihood of full resolution drops 20% every 3 months
- Underpaid or denied claim
- Unresolved patient liability
- Poor patient billing experience

x High bad debt ratio
x High volume of denials x High cost to collect
x Missed revenue

Ideal comprehensive strategy

Financially cleared patient

Collecting upfront increases the likelihood of payment by 50%

Financially secured accounts — Educated patients — Required authorizations

Denial reasons for prevention Process improvement

50% of denials originate from front-end errors

Tailored billing and collections

- Low bad debt ratio
- Minimal denials
- Low cost to collect
- Accurate reimbursement

Key Components of a Comprehensive Financial Clearance Program

POS Collections	Patient Liability Estimate Accuracy	Registration Quality
2% of net patient revenue (NPR)	99% accurate to final bill	100% patients financially cleared

Correct demographic info	Accurate, complete patient coverage	Authorizations identified and obtained	Patient's propensity to pay	Accurate patient estimates	Payment options and counseling	Verify Registration quality
Deploy scalable, repeatable processes						
Provide continuous colleague education and targeted training						
Automatically verify patient identity (name, address, social security number and date of birth) to **reduce fraud and prevent denials**	Verify patient coverage and benefits prior to service to prevent denials.	Determine if service approval is required and obtained as needed to prevent authorization-related denials.	Leverage health care-specific propensity-to-pay scores to tailor patient engagement and increase probability of full resolution.	Calculate patient liability estimates within 99% accuracy of final bill to increase likelihood of account resolution.	Accept multiple forms of payment to accelerate cash and improve patient satisfaction.	Verify registration quality with real-time alerts to prevent manual rework and avoid denials.
	Leverage eligibility enrollment specialists to screen and enroll uninsured patients for Medicaid and other funding resources to reduce bad debt risk.			Educate patients on benefits and liability to enhance the patient experience and reduce bad debt risk.	Leverage financial counseling experts to help patients understand financial obligations and reduce bad debt risk.	

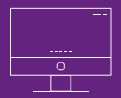
- Process and Strategy
- Education
- Technology
- Service

Key Components of a Successful Billing and Collections Program

Bad Debt

Gross write-offs = <3% of NPR




Accurate, timely claim submission	Specialized follow-up resources	Quality patient interactions	Technology-enabled workflow	Underpayment and denial recovery	Business intelligence	Regulatory compliance
Deploy scalable, repeatable processes						
Provide continuous colleague education and targeted training						
Leverage automation to effectively manage the claim and remittance process to drive cash flow consistency.	Segment accounts with propensity-to-pay logic to maximize productivity and accelerate cash flow.	Utilize multiple creative solutions for patients to pay bills to decrease cost to collect and maximize collections.	Ensure staff work the right accounts at the right time to maximize productivity, reduce cost to collect and maximize collections.	Accurately forecast, identify and capture all net revenue contractually owed to accelerate cash.	Leverage trending and root cause reporting to enable data-driven decision making, denials prevention and process improvement.	Ensure all collections activities meet complex industry regulatory compliance to avoid audit risk.
	Conduct seasonal campaigns to target key accounts at specific times to increase collections.	Measure call quality to ensure customer satisfaction.		Leverage insights to improve upstream processes to prevent ongoing revenue loss.	Employ patient scoring system to prioritize patient contact to reduce cost to collect.	
		Resolve accounts in an individualized and personal manner to improve patient satisfaction and reduce write-offs.		Deploy experienced, specialized teams to identify and recover revenue to reduce cost to collect.	Utilize business intelligence analysts to enhance workflow and drive process improvement.	

- Process and Strategy
- Education
- Technology
- Service

Key Components of Service

Reporting

- We are informed by existing clients that our reporting packages are far superior to those of our competitors.

LiveVox

- We drive world-class productivity. Our PARs take more inbound and make more outbound calls.

Patient-Centric Approach

- Clients don’t lose sleep worrying about patient complaints. We use an unbiased third-party agency to score our calls.

Compliance and Legal Expertise

- Our sole focus on healthcare and licensing in all 50 states provides clients unmatched depth and breadth of knowledge.

REAL-LIFE CLIENT EXAMPLES

SUCCESS STORY #1

For a Midwestern faith-based institution…

nThrive generated $3.5 million more cash than a competing vendor.

Our customized program targeted higher levels of efforts on those accounts with the **highest propensity to pay** and applied specialized resources on **high-dollar balanced accounts**.

SUCCESS STORY #2

For a Southeastern health care system…

nThrive drove an incremental $500,000+ of cash in three months

through the initiation and execution of a strategic tax season discounting campaign on aged accounts, targeting selected account types and balances with varying levels of discounts to **drive resolution** and **generate significant cash**.

SUCCESS STORY #3

For a Southeastern faith-based health care facility…

nThrive provided significant health care account resolution compliance and legal guidance,

assisting the client in enhancing its compliance processes and managing multiple potential claims against the client to resolution and potential litigation prevention.

In particular, nThrive provided guidance in terms of how the **Telephone Consumer Protection Act** can be applied to health care facilities and how health care providers can reduce the risks of litigation created when providers attempt to communicate with patients via telephone.

SUCCESS STORY #4

For a Northeastern regional health system…

nThrive increased recoveries by approximately 14%

versus the client's other vendor as a result of utilizing **propensity-to-pay analytics** to apply increased diligence on accounts with higher predicted ability to resolve their accounts.

Key Takeaways

- Treat the patient as a consumer
- Manage patient liability holistically, not in silos
- Make patient financial clearance a priority
- Tailor collection efforts

Deploy the right combination of strategy, education, technology and services

Questions

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health care for every one in every community.℠

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When our health care providers are healthy and productive, our world is too.

nTHRIVE CULTURE

nThrive is made up of people who are passionate about creating real change in the health care industry.

6,650+ qualified professionals across the nation

5,000 + client partnerships

19 offices nationwide and abroad

30+ years of health care experience

nTHRIVE OPERATIONS

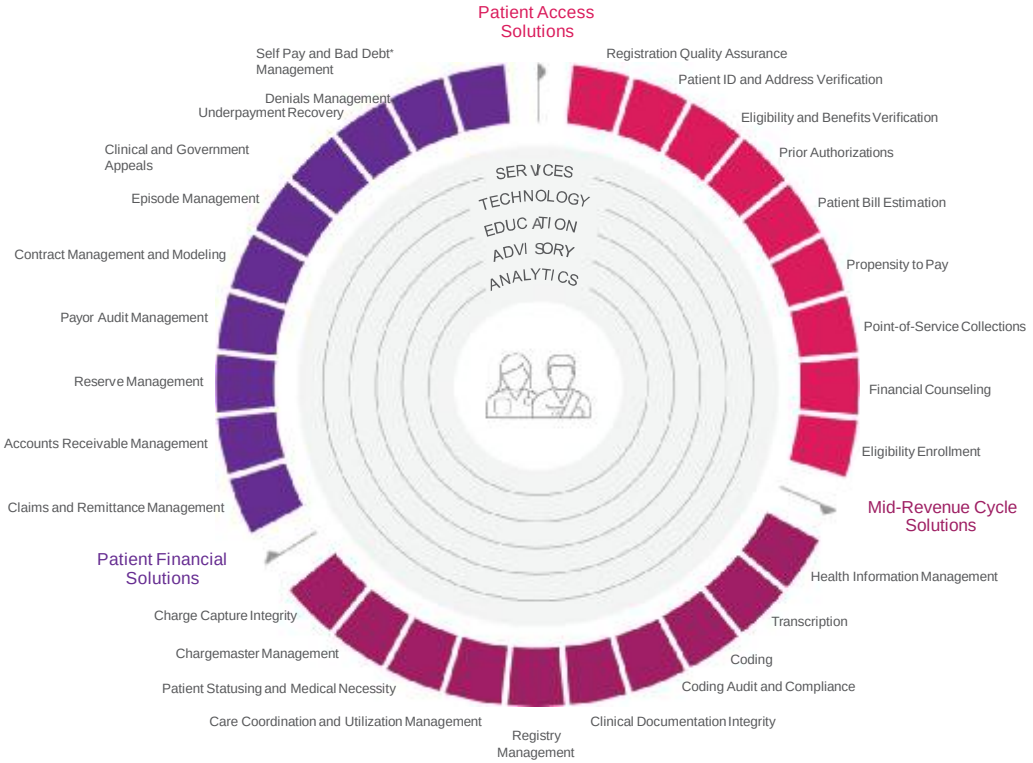
$1.3T gross charges processed annually

225M+ claims processed per year

15,000 + contracts loaded annually

nthrive℠

nThrive is focused on giving providers the tools necessary to improve the health care experience for everyone through our Patient-to-Payment℠ approach.



*Bad Debt Collections are provided by Optimum Outcomes, Inc., a separate entity owned by nThrive, Inc.

INDUSTRY ACCOLADES

Claims Management and Revenue Cycle Outsourcing

Transcription Services

HIM Technology