SEE YOUR REV CYCLE DIFFERENTLY

BRING PATIENTS' INSURANCE COVERAGE OUT OF HIDING

and onto your bottom line

WAYSTAR

Eligibility

Since the Affordable Care Act's (ACA) health insurance marketplaces (aka, "Exchanges") started offering health insurance in 2014, more Americans are covered than ever before. The trouble is, patients don't always know what coverage they have, or circumstances prevent providers from verifying insurance coverage pre-service.

This is no small problem. For example, in the last 16 years, hospitals provided $538 billion in uncompensated care,[1] which includes bad debt and charity care, and there's no relief in sight. Consider these facts:

- **80% of newly insured patients are high nonpayment risks because of skyrocketing deductibles, increased co-pays and tighter household budgets.[2] The risks are real: 81% of self-pay net revenues go unrecovered.**
- **The Centers for Medicare and Medicaid Services (CMS) is expected to cut disproportionate share hospital (DSH) funds by $43 billion between 2018 and 2025,[3] reducing federal relief for uncompensated care.**
- **Eighteen states chose not to expand Medicaid under the ACA, leaving millions of vulnerable patients uninsured.[4]**

What's a provider to do? We recommend taking proactive steps to find hidden insurance coverage so you can collect more revenue from both patients and their insurance providers, lower bad debt and improve your bottom line. We explain how.

What's inside:

1 American Hospital Association Uncompensated Hospital Care Cost Fact Sheet, December 2016.
2 2010 Commonwealth Fund Biennial Health Insurance Survey
3 "Billions in federal uncompensated-care funds to be cut starting in October," by Virgil Dickson, Modern Healthcare, July 28, 2017.
4 Status of State Action on the Medicaid Expansion Decision, KFF.org.

1 Why you don't know about patients' health insurance coverage

A surprising percentage of self-pay and charity care patients have full or partial health insurance coverage that you – and they – don't know about. Payers have no proactive way to share coverage details with patients and providers, and plans and contracts are increasingly complicated and ambiguous. This lack of knowledge is compounded by a host of circumstances that make it difficult to capture insurance information. Here are the typical scenarios.

Emergency room visits and arrival by ambulance

- EMTALA requirements and best practices indicate that the patient must be screened and stabilized before inquiring about payment or health insurance status.
- Patients often don't have insurance cards with them.
- Patients may be unconscious or in life-threatening conditions.
- Uninsured patients use the emergency department as their primary care physician, knowing they can't be refused care.

Patient confusion

- Patients who signed up through ACA exchanges may not know what insurance companies they're with.
- Patients have a new insurance plan, they don't have their cards yet or they're unfamiliar with plan specifics.
- Patients don't know they're eligible for worker's compensation or COBRA.

Retroactive Medicaid

- Patients can get retroactive Medicaid coverage for up to three months before they apply, assuming they met eligibility requirements when service was rendered.

Dual coverage

- Patients don't know they're covered by more than one insurance company or government entity.
- Patients have secondary and tertiary insurance.

Charity care

- Patients with high deductibles and copays withhold insurance information to try to qualify for charity care.

Disability

- Disability patients must complete a lengthy paperwork process to get coverage.

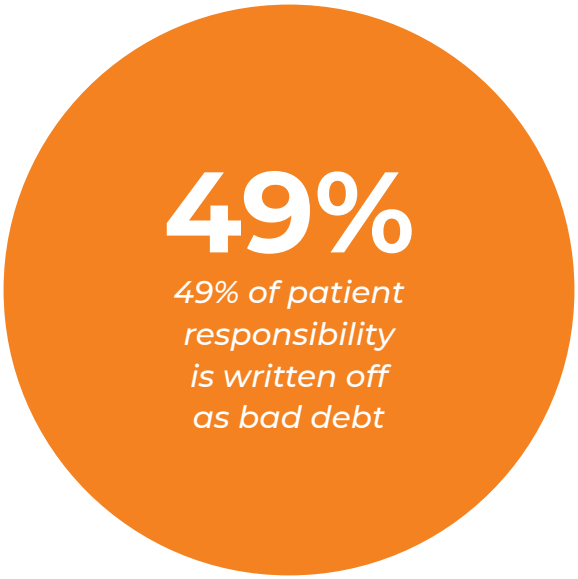
Worker's compensation

- Patients covered by worker's compensation provide their employers' insurance information instead of their own, which can delay payment.

2 The impact of missing or hidden coverage

Tracking down patients' missing or unknown health insurance coverage is time-consuming, costly and can involve multiple functions in the revenue cycle.

At the front end, patient access staff try to verify coverage before scheduled appointments. If they can't, either the billing staff will write off the accounts, the AR staff will start the collection process or the accounts are outsourced to a third-party company for collection. Unfortunately, after all this, 49% of patient responsibility is written off as bad debt, which negatively impacts cash flow, profit and patient relationships.



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3 Self-pay patients the best medicine

True self-pay patients generally pay about six percent of what they're billed, compared to 15.5% for "self-pay after insurance patients," or those with high-deductible plans who still owe a lot after coverage kicks in. To get the higher payback, providers are willing to invest in uncovering hidden insurance. Here are typical processes.

Method	Process	Upside/ downside
Manual contact	Call each payer or visit payer website to check for coverage If patient not covered, start again with next payer	• Phone calls average 30 minutes; website visits average five minutes • Some payers limit patients discussed per call • Labor-intensive to contact numerous payers Increased AR days • Can jeopardize timely filings
Transactions	Send 270 transaction to each payer to check for coverage Based on 271 responses, if coverage is inactive, start again with next payer	• Less time-consuming than manual process • Labor-intensive to contact numerous payers • Risk of sending to wrong payers • Can jeopardize timely filings
Outsourcing	After specified days in accounts receivable (AR), outsource to third-party call center	• Staff time and energy already invested • Adds to cost to collect loss of control
Coverage detection rate	Use automated processes to identify coverage, eligibility and recoverable opportunities	• Finds more coverage than manual processes • Reduces AR days • Lowers costs and labor requirements • Improves patient satisfaction

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5 Becker's Health IT
6 "5 tips for identifying whether self-pay patients have hidden health coverage," by Kelly Gooch, Becker's Hospital CFO Report, April 11, 2017.

4 Why one coverage detection solution out performs other options

Without the proper tools and technology, searching for active health insurance coverage on self-pay patients can be like looking for a needle in a haystack.

Waystar's Coverage Detection solution overcomes the barriers with powerful, proprietary financial intelligence based on 15 years of data from hospitals, health systems, physicians, specialty groups, ancillary providers and payers. The solution identifies active and inactive coverage, no matter where patients enter the system, and routinely finds 5%-15% of billable insurance – 2.8 times more than other options.

How Waystar's coverage detection solution works

Step 1 Identify hidden coverage

Waystyar owns proprietary data on one in eight patients in the U.S. Our expansive data intelligence engine finds hidden coverage by combing through millions of patient attributes and billions of transactions across the healthcare continuum. Staff can request information at patient access or send batch files ahead of time on new self-pay patients or patients with scheduled appointments. Files can also be processed later on in the revenue cycle as either a final effort to search for hidden coverage or to help with eligibility related claim denials, the results of which are vital in closing the ever-elusive gap on uncompensated care.

Step 2 Confirm coverage is active

Using proprietary algorithms, data mining and machine learning, Waystar's Coverage Detection solution aggregates insights and leverages 1,200+ payer connections to confirm coverage.

Step 3 Deliver results

Within minutes of the request, ZirMed's Coverage Detection solution delivers actionable reports of active and inactive coverage for all patients provided.

Benefits to your organization

- **Increased staff productivity:** Eliminating manual processes reduces time and hassles.
- **Lower costs:** It's twice as expensive to try to collect from patients than payers.
- **More control:** Resolving self-pay accounts in-house eliminates the need to outsource.
- **Higher patient satisfaction:** Patients appreciate finding coverage they weren't aware of and staff avoids trying to collect from patients mistakenly identified as self-pay.
- **Higher revenue and profit margins.** Increased collections reduce bad debt and inappropriate charity write-offs.
- **Lower AR days and better cash flow.** Identifying active coverage faster allows earlier and more complete collections.
- **Easy, cost-effective implementation.** Like all ZirMed solutions, Coverage Detection is cloud-based and requires no software installation or hardware upgrades.

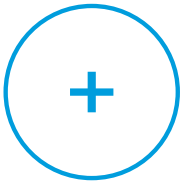
EXPLORE OUR ALL-IN-ONE PLATFORM

Eligibility

Verify insurance coverage to reduce claims rejections and denials

Revenue Integrity

Find missing charges and capture revenue you're due

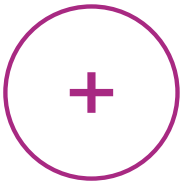


Claim Management

Automatically submit and track claims, and reduce AR days with intelligent-driven workflow

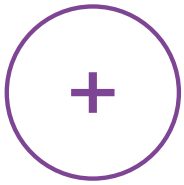
Denial Management

Prevent denials and automate appeals



Contract Management

Gain control over payer negotiations, manage your contracts and recover owed revenue



Patient Financial Experience

Collect patient payments, determine propensity to pay and improve the patient experience

Agency Management

Get insights into outsourced agency effectiveness

Social Determinants of Health

Use data on broad factors that influence healthy to improve clinical outcomes

Get in touch today at
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ABOUT WAYSTAR

Waystar simplifies and unifies the healthcare revenue cycle with innovative, cloud-based technology. Together, our technology, data and client support streamline workflows and improve financials for our clients, so they can focus on their patients.