Striking the Right Balance

Increasing Patient Collections and Satisfaction in a Consumer-driven Climate

BY TOM STAMPIGLIA

A few short years ago, an organized and efficient back office was all a healthcare provider needed for an effective revenue cycle management strategy. As long as claims were successfully submitted and reimbursement was collected from insurers for medical services rendered, a group had all of the financial resources required to stay afloat.

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Unfortunately, this is no longer the case. With consumer-directed health plans rapidly gaining market share, deductibles and coinsurance amounts are rising steadily. As a result, the proportion of revenue due from patients has soared and is projected to account for almost a third of a provider's revenue source by 2012.[1]

Meanwhile, payer reimbursement has declined by 8.9 percent over the past decade,[2] placing even more pressure on already thin margins. Add to that a lingering recession and the growing population of uninsured patients, and it's never been more challenging for providers to maintain a profitable practice.

To address these changing dynamics, provider groups have begun transitioning processes that historically belonged in the back office to the front end of the revenue cycle. By placing greater emphasis on collecting co-pays and deductibles at the time of service, supplying patient estimates in advance of procedures, and employing a variety of financial counseling tools, healthcare providers can not only meet the demands of today's consumer-driven climate, but also can boost patient collections, avoid denied claims, reduce patient bad debt write-offs, and strengthen the bottom line.

Managing Expectations

For many provider groups, the patient collections process starts with an eligibility and benefits check long before a patient steps into the waiting room. By confirming a patient's coverage at or before the time of service, providers can gather the details needed to begin calculating exactly what that individual's financial responsibility for treatment will be.

Beyond confirming whether a patient is enrolled in a specific health plan, the latest patient insurance and benefits verification software combined with patient portion estimation technologies enables providers to verify coinsurance and deductible amounts for specific types of service—for example, some applications can differentiate coinsurance for an MRI from DME or surgical rates. Benefit coverage dates and other details can also be obtained in the same check. Provider groups can use the same tools to confirm eligibility at multiple points throughout

the revenue cycle, from pre-arrival and check-in through charge entry, claims submission, and posting. As a result, providers can minimize the need for time-consuming phone calls with payers and ensure that all eligibility information is both accurate and up-to-date, ultimately leading to fewer claim denials, payment delays, and patient bad debt write-offs.

But even with the latest eligibility and benefits data at their fingertips, many providers are discovering that patients are confused about their health benefits, what they cover, and what they don't. Educating patients about their out-of-pocket responsibilities has become an imperative for provider groups looking to optimize collections—they are basically being tasked with acting as financial counselors to help their patients navigate the myriad of information.

At Portland-based Oregon Health & Science University Medical Group (OHSU Medical Group), patients receive estimates of their financial obligations well in advance of treatment. The practice, which handles nearly 700,000 ambulatory visits annually, began providing estimates in 2009 as part of a larger strategy aimed at minimizing bad debt.

OHSU's biggest challenge to providing estimates was determining exactly what the insurance company would allow for a particular set of procedures. Without this information, it was nearly impossible to calculate the patient's portion. OHSU was able to overcome this obstacle by deploying pricing software that can accurately determine a patient's financial responsibility. The staff member simply enters the procedures to be performed and the application calculates the allowable based on the organization's specific payer contracts and associated reimbursement rules. Then, applying real-time electronic benefit information, the application determines the patient's portion of this allowable.

With this approach, the group has been able to increase collections by an average of $42,000 a month. Since patients no longer have to wait for weeks following a procedure to receive an explanation of benefits outlining their financial obligations, they are able to start planning how to budget for their out-of-pocket expenses right away, giving them ample time to explore alternative payment options if needed.

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Starting a Dialogue

While producing estimates is an important step in the right direction, it's just one component of a comprehensive approach to patient collections. At Arizona Oncology, estimates are used to initiate personalized financial counseling sessions with patients about their out-of-pocket responsibilities.

The 41-physician group generates nearly 450 estimates each month for chemotherapy, radiation therapy, and other high-cost services. By focusing on educational efforts and assessing the financial situation of each patient on a case-by-case basis, the organization has been able to set more-realistic expectations regarding health-related expenses and engage in productive discussions about payment plans and other flexible payment options.

As a part of this patient education initiative, Arizona Oncology also recently introduced a new patient-friendly statement that includes a glossary of common insurance and billing terms so that patients can better understand the differences between co-pays, deductibles and coinsurance, and how each ultimately impacts the final bill. Taking extra steps like this one helps Arizona Oncology to minimize any frustration that patients may encounter when reviewing medical bills and create a more positive and collaborative experience for patients. The patient-friendly estimates and billing statements have also reduced the number of billing inquiries the practice receives, saving valuable staff time and speeding overall cash flow. This proactive approach has also helped the group avoid denied claims.

Thinking Like a Retailer

As enrollment in high-deductible, consumer-directed health plans continues to grow, healthcare organizations find themselves operating more like retail businesses. With countless providers acting as "creditors" for patients—whether administering payment plans or chasing down bad debt—many have begun adopting practices commonplace in the retail setting to help bolster the bottom line.

For Austin, Texas-based CardioThoracic Vascular Surgeons (CTVS), this means offering patients a discount for prompt payment of medical bills. The 28-provider group, which increased patient revenues by more than 25 percent after implementing a patient estimating tool in 2005, started exploring how technology could further improve its approach to collections last year. Like many providers, CTVS staff found themselves overwhelmed with the effort required to track down patient balances and needed a way to minimize the time and expense required to secure the patient's portion of fees for surgeries and other medical procedures.

In addition to placing a greater emphasis on short-term payment plans and actively following up on outstanding balances, the group leveraged technology to help it better gauge a patient's propensity to pay medical bills. The tool initiates a real-time soft credit check, similar to the process used to pre-approve a consumer for a credit card. Since the soft credit check doesn't impact the patient's credit rating or appear

on the patient's credit reports requested by lenders, it is suitable for frequent, everyday inquiries.

CTVS staff then uses the credit score to guide them in determining optimal payment policies and terms. Primarily, the group relies on these data to calculate the discounts it may offer patients as an incentive for paying balances in a timely manner.

Since adopting this approach, CTVS has found that many patients are receptive to paying their bills quickly if they feel they are receiving something in return. And, by placing a time limit on the offer, the group is able to create a sense of urgency, helping to further increase the likelihood that patients will act on the balance sooner rather than later.

Propensity to pay tools can be utilized in a variety of ways.

Propensity to pay tools such as the one CTVS implemented can be utilized in a variety of other ways, from flagging patients who may be candidates for charity care to helping provider groups pinpoint which bills to turn over to an outside collection agency. They may also help to identify candidates for flexible payment arrangements such as recurring payment plans, which allow providers to bill a patient's credit card for a predetermined amount on a monthly basis. This approach not only eliminates the hassles associated with mailing paper checks and coupons each month, but also streamlines processes for staff and boosts overall efficiency.

As adoption of these tools becomes more widespread, online insurance eligibility and benefits verification, cost estimation, propensity to pay, and recurring payment plan capabilities have become more tightly integrated, allowing providers to easily and efficiently manage patient collections from one central application. With this approach, provider groups can not only streamline workflow and minimize time-consuming manual processes, but also speed cash flow and enhance customer service.

The Bottom Line

At a time when patient bad debt poses a serious threat to profitability at healthcare organizations nationwide, providers must examine their existing revenue cycle management processes and determine how they can be revamped to be more proactive, efficient, and patient-friendly. Whether requesting co-pays and deductibles up front or collecting fees post-service, providers need to educate patients about their financial responsibilities every step of the way. Providers that embrace this new role as financial counselor and take advantage of all the benefits that technology has to offer will be better equipped to capture patient balances, avoid denials, increase patient satisfaction, and drive revenue.

References

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