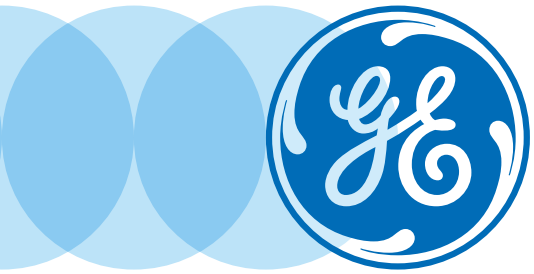
GE Healthcare

Maximizing Point of Service Collections: Improve Health System Financial Performance

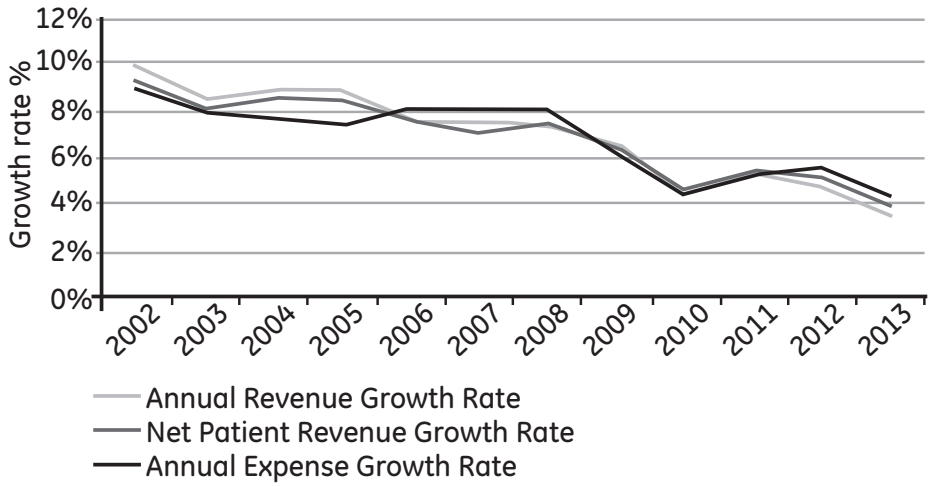
White Paper



Abstract:

Changes in healthcare have put a spotlight on front-end collections. Revenue coming directly from patients due to the proliferation of high deductible health plans is growing and, as a result, point of service collections has become more complex. To successfully manage the increased pressure on patient collections requires a different approach for many organizations, one that focuses on people, processes, technology, and partnerships to ensure providers achieve as close to 100% of net collections as possible. This white paper discusses the pressing need for health systems and practices to shift the focal point of revenue cycle improvements to front-end workflows to help reduce costs and improve financial performance.

Revenue growth reached all-time low and outpaced by expense growth for second consecutive year



Note: The data points prior to 2009 are from different samples sets. However, the multiple years of data still accurately reflect the trend in the industry over this period.

Market forces are creating pressure on consumers

A convergence of regulatory, patient (consumer) and payer forces is presenting a host of new, rapidly evolving challenges for provider organizations. As healthcare transitions from volume-based care to value-based care, foundational changes are transforming the way healthcare is delivered and consumed.

The implications are significant for every stakeholder in every segment of healthcare:

- Payers will reward value over volume. In January 2015, the U.S. Department of Health & Human Services (HHS) set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.[1] Two days after HHS unveiled significant Medicare payment reforms, a group of commercial payers, providers, and industry partners says it is committed to putting 75% of its business into value-based models by 2020.[2]
- Revenue growth has reached an all-time low while expense growth continued to outpace revenue growth. The revenue growth rate reached an all-time low of 3.0% in fiscal year 2013 and marked a second consecutive year of decline. The slowdown is a steep drop from the 5.1% growth recorded in 2012 and historical growth rates that routinely exceeded 7.0% (see chart above[3]).
- Provider margins will be squeezed. The Affordable Care Act (ACA) will usher 32 million new patients into the healthcare system, while ushering out $415 billion in fee-for-service payments by 2022.[4]
- Employers are adjusting to the rising cost of health insurance by sharing the burden with their employees, through increased premiums, copays and coinsurance to out-of pocket maximums and HDHPs. In 2014, HDHPs will constitute 76% of insurance plans and per capita out-of-pocket payments are projected to increase 31% by 2022.[5]
- Patients will pay more. Over the past decade, total premiums have increased substantially, from 14.9% to 21.6% of median household income.[6] Employee contributions to premiums and out-of-pocket expenses have risen 32% since 2009, and the percentage of workers enrolled in High Deductible Health Plans (HDHP) has increased six-fold since 2006, from 4% to 26%.[7]
- Healthcare executives and policy analysts are concerned that the people least able to afford their medical bills will be most likely to select the cheaper "bronze" plans available both inside and outside the exchanges, which pay only 60% of costs. Those plans carry a steep out-of-pocket maximum of $5,950 for individuals or $11,900 for families which means hospitals are likely to face a situation where more revenue is at risk—even as more people gain coverage.[8]

The dramatic increase in patient liability brings with it significant risks to provider organizations in the form of out of pocket payments. By one estimate, 81% of self-pay patients' bills from providers are never collected, and 55% of patient responsibility after insurance ends up as bad debt.[9] As such, the traditional approach of attempting to collect patient liabilities after service has been delivered must change – and fast.

Health systems are going to be under enormous pressure to improve their ability to collect out-of-pocket revenues. Moving forward, providers must understand the burden placed on patients and their families and find creative ways to help them meet their financial obligations.

Front-end improvements drive better financial outcomes

Shifting the focal point of revenue cycle improvements to front-end workflows reduces costs, and improves performance throughout. Improving point of service collections helps maximize revenue by:

- Reducing denials – Denials negatively impact financial performance in two critical areas. First, denials are more likely to become bad debt than clean claims and second, the cost of reworking claims once they have been denied, which can range from $25 to $40 per claim,[10] often outweighs the benefit of the claim.
- Accelerating collections – The benefit of accelerating collections or reducing days in A/R can be millions to the bottom line. Not for profit hospitals for example, have a median day in A/R of 49.8, reducing that by one day would represent over $1.5M of revenue. Cash on hand is critical for everyday items such as payroll, but it also enables organizations to invest in areas that are critical for achieving growth and improving patient care.
- Increasing likelihood of patient payment – Verifying patient insurance coverage, benefits, cost-sharing requirements and deductible status, at the time of or prior to service, can improve upon first pass denial rates and patient satisfaction. Accurate liability estimates are fundamental to stronger front-end collections as a patient well-informed of their responsibility is more likely to pay at the point of service consumption. Moreover, accurate estimates can help curb denial rates and minimize patient overbilling, which also results in costly administrative rework and lowers customer satisfaction rates.

In addition, upfront information satisfies consumer demand for cost transparency and enables staff to provide stronger customer service. The convergence of financial, industry and regulatory challenge on front-end collections will test even the strongest revenue cycles, however those who are successful at adjusting will be best positioned to capitalize on new care models including population health, assume greater financial risks to and access vital sources of capital at competitive rates.

For providers, relieving the pressure on financial margins by improving front-end performance is critical, and they are trying to do it in several ways, including:

- Improving efficiency by identifying areas for automation to streamline billing operations with technologies to work 'smarter not harder' and to meet the needs of billing requirements and reimbursement models.
- Leveraging next generation technology such as task management to identify high value issues and dedicate resources accordingly in real time to help accelerate the revenue cycle.
- Acquiring or affiliating with strategic partners to increase purchasing power, lower costs and increase patient access.

Four Steps to Maximizing Point of Service Collections

To meet the evolving demands of this high-risk environment, while maintaining financial performance, provider organizations must focus on strategies and methodologies to improve point of collections. Provider organizations who invest in **people, process, technology** and **partnerships** as an eco-system put themselves in a position to be successful. Approaching these four areas together enables organizations to deliver desired financial outcomes by looking at revenue operations holistically. Below are recommendations for approaching these four key areas:

1. People

Front-end clinic staff must be the tip of the proverbial revenue cycle management spear. They know, as well as anyone, that the healthcare landscape is changing. They themselves may be enrolled in health plans with increased deductibles and coinsurances, and many will already realize that the viability of their office depends upon the organization's ability to collect. Ensure front-end staff is prepared to optimize the tasks required during the patient's first arrival. Arm them with the tools and training they need to help drive up front-end patient collections.

A. **Establish clear goals** – Foster a consumer-driven environment with clearly defined Key Performance Indicators (KPIs). Collect as much patient information as possible up front, starting at the initial patient interaction point. For the provider, collecting correct, comprehensive data on the front end means more agility on the back end. For the patient, collecting information efficiently and effectively means a more positive experience. A high impact area with the potential for high patient satisfaction, the point of interaction can be an important source of competitive advantage.

B. **Measure, measure, measure** – Consistently measure performance against goals. The following are KPIs that provider organizations should plan to measure to ensure success:

   i. Percent of net patient revenue collected at or prior to time of service
   ii. Self-pay days in AR
   iii. Percent of accounts and dollar volume sent to collections
   iv. Point of Service collections accuracy rate
   v. Eligibility verification rate
   vi. Net collections ratio
   vii. Bad debt write-offs

KPIs should be tracked by ambulatory and hospital billing offices to best determine areas of performance excellence and opportunities for organizational improvement. But these KPIs are also just the beginning. There are many established KPI's that can help measure the health of discrete areas of front-end revenue cycle performance. The best way to identify areas of poor performance is to measure everything and make adjustments.

C. Make everyone accountable – Aligning individual performance and process improvement with organizational KPIs supports delivery of excellent patient service. Accountability doesn't work if everyone is not held to equal standards. When staff trusts that everyone in the organization is accountable – including leadership – then there's nowhere to hide. With accountability established, the detailed reports created to measure outcomes will now become powerful tools that allow organizations to promote successful behavior and positively engage underperformers.

D. **Measure and communicate** – Develop a communications plan – and then execute it! Consistently communicate to staff key successes, losses, and areas of improvement. Celebrate success and put a spotlight on areas of deficiency that were identified and addressed.

E. **Reward success** – Provide incentives – and disincentives. These are often an effective way to encourage front-end staff to improve point of service collections. Providers can reward top performers through variety of recognition programs, from internal collector of the month-type recognition to cash bonuses and gifts.

2. Process

Provider organizations can no longer rely on post-insurance patient collections. More revenue coming from patients puts more revenue at risk for becoming bad debt. Providers must adapt to this changing landscape by building and enforcing collection workflows prior to care. Key steps include:

A. Estimating patient liability for anticipated care delivery.

B. Contacting patients three to seven days before their scheduled arrival, to explain what care they can expect and what they can expect to pay for it.

C. Collecting anticipated patient liabilities prior to care delivery. Appointment reminder calls are the perfect vehicle for taking partial or complete payment for projected liabilities.

D. Implementing a credit estimation process that enables providers to identify patient populations that may be at greatest risk of incomplete payment of their liabilities, and build in requirements around increased deposits or other measures to ensure good care does not result in bad debt.

E. Consider facility improvements. Oftentimes organizations will work to achieve the best process and workflow within the constraints that exist. That includes physical constraints. If front-end collections processes can be improved by making modifications to the physical structure of the facility then the investment should be considered. Simply by making a modification, such as adding additional front desk space or building an office with a closed door to facilitate financial counseling can make a positive impact on front-end collections.

3. Technology

Technology is the key enabler to help provider organizations meet the changing landscape. Software tools and services are now available to support:

A. **Accurate estimation** of patient liabilities, based upon eligibility response information as to remaining deductibles, copayments and the like, integrated with past payment profiles, payer contracts and other data sources. While insufficient collections are a significant cost for organizations, collecting 'too much' – for example copays and coinsurances for a screening mammogram that is covered at 100% by the insurance company – is both a significant source of patient frustration, as well as costly in terms of refund processing.

B. **Integration** of patient liability estimation and payment collections within the pre-arrival or arrival process, so this is not a step that gets 'forgotten' in the rush to manage patient arrivals. Visibility into current patient account information, such as last statement balances, and whether patients are current on any budget plans, is also a key point of integration.

C. **Tracking tools** for provider organizations to identify which staff members are best at collecting. Organizations can provide excellent tools and training for their end users, and have a solid process, but without tools to track which of their staff are meeting their collections goals it is very difficult to ensure a high level of performance overall.

D. **Financial planning** tools enable providers to work with patients to build plans for paying down their responsibility. When integrated with credit card management technology a plan can be developed that ensures the provider gets paid while making it more manageable for the consumer.

E. **Additional tools** to determine credit risk, automate budget plan setup and payment, assist with Medicaid or Health Exchange insurance applications for uninsured patients, effectively manage applications for patient financial assistance, among others, can all help ensure that collections from patients are maximized, with a minimum of effort on the part of provider organizations.

4. Partnerships

To satisfy process, training and technology needs, provider organizations need technology partners that can help them meet long-term goals. Technology partners have the resources and expertise to align their solutions with the organization's needs. The best technology partners ensure configurability for the provider's unique payer mix, furthering competitive advantage, and helping organizations adjust to and make the most of changing reimbursement models.

Centricity™ Solutions for Financial Management

Centricity Solutions for Financial Management is a powerful combination of software, professional services and ecosystem partners that work together to help healthcare organizations optimize their revenue cycle operations, implement risk-based payment models, and better connect with their payers. Centricity Solutions for Financial Management includes:

- **Centricity Business** for enterprise-wide revenue cycle management
- **DenialsIQ™**, a predictive analytics solution that proactively identifies claims likely to be denied
- **Centricity Financial Risk Manager**, which helps organizations manage fully capitated contracts
- **Centricity EDI Services**, an all-payer clearinghouse
- **Centricity Calibrate Services**, a new services offering jointly developed with Accenture, designed to improve more than 70 Key Performance Indicators

Centricity Solutions for Financial Management from GE Healthcare is unique in that it connects seamlessly with both clinical IT systems and payer IT systems. Centricity Solutions for Financial Management integrates clinical data from virtually any electronic medical record (EMR) directly into financial operations.

In addition, the solutions include tools to share revenue cycle information directly with payers to better manage risk and ensure that healthcare organizations are paid for the services they provide.

Outcomes-driven

Software-enabled solutions from GE Healthcare have helped providers achieve the following financial and operational improvements:

- Virginia Commonwealth increased their co-pay collection rate from under 60% to more than 80%[11]
- Schumacher Group make significant workflow improvements and reduce rework costs by approximately $3.8 million per year[12]
- WESTMED Practice Partners reduce their cost to collect to less than 4%[13]
- University Physicians, Inc Improved eligibility verification rate from 77% to 93%[14]

Conclusion

As the healthcare payment universe transforms around them, provider organizations face an array of challenges to remaining financially successful. Capturing patient payments prior to or at the point of service is a key success factor. Assessing people and process needs effectively for up-front patient collections is important, as is finding the right technology tools and partnerships to ensure they do so efficiently.

Success depends on strong financial management solutions. Keeping the Health System financially viable calls for strong results that allow providers to achieve clinical missions, make improvements and maintain quality. Clinical systems alone aren't enough; these challenges require enterprise-wide financial management tools, workflows, best practices and the right partner to help maximize financial performance. Preparing now will help ensure success in the future.

Imagination at work

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[1] U.S Department of health & Human Services, Press release: Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value, January 2015.

[2] HealthLeaders Media, Private Players Launch Value-based Task Force, John Commins, January 2015.

[3] Moody's Investors Service.

[4] National Health Expenditure Projections 2012-2013, Center for Medicare & Medicaid Services.

[5] Healthcare Consumption Expenditure - National Health Expenditure Projections 2012-2022.

[6] Health Care Spending Slowdown: The Consumer Paradox. Dobson & DaVanzo. 2014.

[7] Healthcare Consumption Expenditure - National Health Expenditure Projections 2012-2022.

[8] Healthcare Consumption Expenditure - National Health Expenditure Projections 2012-2022.

[9] Improve Patient Collections: Don't just ask...ASK!! Elizabeth W. Woodcock, author MEdiRevv White Paper, 2013.

[10] MGMA and Cost to appeal denial, analysis by Susanne Madden, The Verden Group.

[11] Virginia Commonwealth Medical Center case study.

[12] Schumacher Group Case Study, 2014.

[13] WestMed Practice Partners case study, 2014.

[14] University Physicians, Inc. Case Study, 2013.

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