Patient Responsibility Estimation and Point-of-Service Payments: Essential Technology to Accelerate the Revenue Cycle and Impact Consumer-Directed Healthcare

An Emdeon
White Paper

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Simplifying the Business of Healthcare

Introduction

In an emergency situation, medical personnel converge to triage patients—to assess severity and urgency of need and administer care accordingly. But what if they lacked supplies or had out-dated tools? What if a skilled, experienced medical team didn't have the equipment required to provide aid? Undoubtedly, patients would suffer.

Of course, the above described scenario is rather implausible today in U.S. society. Emergency medical teams typically have basic supplies to address urgent needs. However, the story is very different each day on the business side of healthcare in many facilities across the country, as registrars and other frontline provider representatives must attempt to "triage" patients' financial and payment responsibilities without benefit of proper tools or technology.

As the healthcare industry continues to shift to Consumer-Directed Health Plans (CDHP), Americans are increasingly responsible for direct payment of their medical care and are trying to act as consumers in the healthcare system with the rise in high deductible and self-pay situations. Unfortunately, too many providers lack the technology they need to offer their patients the adequate estimates, facts and figures upon which they may make decisions and prepare to make payments for their care.

It's not surprising there has historically been a disparity between technology to generate consumer-directed information and the need for that information. After all, consumer-directed healthcare products are a relatively new phenomenon. Marketed in the U.S. since the early 2000s, consumer-directed healthcare products have become increasingly popular in recent years. Having emerged in response to healthcare inflationary costs that negatively burdened the participants throughout the entire system (payers, providers and patients alike), these evolutionary plans have grown in popularity as they have the potential to greatly contain costs. The savings potential over traditional health plans is significant system-wide, up to 15% in the first year as indicated in a 2009 study by the American Academy of Actuaries.

By imposing a consumer market model on healthcare, the consumers of that care are going to need tools that make it possible to use discretion regarding utilization of services. Simply put, if patients are required to purchase their healthcare as consumers, they will need to be able to compare prices and understand those prices related to outcomes and the necessity of the care. From annual check-ups to elective care this evolved consumer-patient will demand an understanding of their financial responsibility and the ability to contrast the providers in their area before making a decision.

Hence, while the prominence of CDHP is growing rapidly, the patient/consumer-facing information exchange and useful tools have been slow to follow suit. It's challenging to change the inner workings of a system long structured to accommodate the transmission of data between providers, payers and intermediaries. With patients not historically part of this transmission, the associated technology itself needs "triaging."

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New Technology Brings Providers & Patients Together on Costs, Payments

As the adage goes, "necessity is the mother of invention." At last, market leaders have developed necessary technology to respond to the altered healthcare model and now, solutions are available for providers at all levels to better exchange information directly with patients.

These new technological solutions are removing the veil that previously separated patients from knowledge of the costs and coverages related to their care. Frontline staff can now easily quote pricing to help a consumer "shop" for their care. They can use these interactive tools during registration—prior to care—to prepare patients for anticipated costs, their share of responsibility and payment options. Likewise, with the empowerment of better knowledge for providers and patients alike, point-of-service payments can be obtained more consistently, allowing for significantly improved revenue cycle management and cash flow.

Taking the Lead for the Market: Information Intermediaries

Who are the "market leaders" developing these technological solutions? Information intermediaries, sometimes referred to as health information networks or historically known as clearinghouses, are well-established as arbiters of financial and administrative data in the healthcare system to facilitate the secure transmission of data between all parties in the revenue cycle. Data and information handled by intermediaries include patient information, insurance coverage verification, claims/denial management and payables and receivables processes.

Intermediaries, covered by HIPAA and subject to all mandates of privacy and security, hold immense historical data that, when acted upon, can lead to highly accurate cost estimating for healthcare services. Working from a vast platform interlinking third-party payers and providers of all types and sizes nationwide, intermediaries possess technology to cull historical cost data and eligibility information. This information can then converge with patient-specific intelligence acquired during registration to calculate reliable estimates of costs for care including patient and insurance liability. These estimates have potential to be a transformative tool as consumerism continues to take hold in the healthcare industry.

These new technological tools are notably advanced from early iterations of web-based estimating tools. Some of these early tools came quickly to the market but did not adequately suit the complex needs of CDHPs. Without ample historical data to draw upon, those first generation estimators functioned inaccurately and did not provide comprehensive or customizable outputs.

In contrast, the tools now available incorporate the multi-layered data available in comprehensive healthcare IT systems and are able to quickly, securely and accurately aggregate immense amounts of data from an array of provider and payer sources to predetermine costs and payment responsibilities for patients.

Bringing Revenue Full Circle with Point-of-Service Collections

Informed patients make better consumers. By offering ample cost and payment information at the initiation of an encounter, providers are able to engage and educate patients so that the financial aspects of their care may be promptly addressed and paid upfront when possible.

As a matter of fact, the health and effectiveness of providers' financial services performance is directly aligned with point-of-service collection. For elective and/or highly predictable, fee-based services, costs are rather simple to estimate. However, many healthcare services are complex in nature, subject to variables deriving from patient-specific insurance eligibility and health conditions, etc, and are therefore less predictable in terms of potential costs. Proper pre-encounter estimation is essential for both providers and patients in order to attain point-of-service payment. Without base knowledge of the costs patients may incur, frontline staff often lack confidence to ask for even a portion of payment during registration. Effective estimation tools help close the loop.

Secondary Benefits of Pre-Service Estimations

While point-of-service collections is a direct benefit of patient responsibility estimating, there are indirect benefits as well. Valid estimates, coupled with eligibility verification, can reveal other coverage possibilities such as charity care options, sometimes even for patients who have traditional coverage. More detailed, accurate information upfront staves off lingering, convoluted collections processes in accounts receivable and lessens administrative efforts required to manage bad debt. As healthcare evolves to more of a retail-like model, the technology to accommodate pre-encounter estimations—and resulting point-of-service collections—is essential to any successful revenue management process.

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Transparency of Costs Removes Barriers to Payment

These new technologies not only aid in shifting more collection opportunities to the front of the revenue cycle and reducing back-end administrative costs, they also remove barriers to ensure a truly transparent process for patients who are learning to approach their healthcare as consumers. Notably, the technology brings patients in direct line with the details of their care: line items costs, treatment options, third-party coverages/approvals and payment alternatives. In offering thorough and transparent information, providers may alleviate patients' fears and concerns regarding costs, establish stronger trust relationships with patients and promote long term good will.

Certainly, transparency is not only best for the provider/patient relationship, it is also essential in order to deter bad debt. If proper responsibility estimates are not provided to patients, the very consumer-driven health plans intended to improve the system may ultimately further burden it, as patients unclear about what they owe are less likely to pay—even in part. For example, presently the self-pay population represents just 5 to 6 percent of hospitals' total net revenue, yet it accounts for 16 to 17 percent of outstanding accounts receivable with ultimately 60 percent of money not collected prior to care written off. Thus, this patient population disproportionately impacts both the revenue cycle and cash flow for providers.

As the self-pay population continues to grow, providers must tap into the resources of new technology to improve transparency of pre-encounter processes, to remove potential system breakdowns and guide better financial outcomes.

Speaking the Language of the Patient as a Consumer

New technology not only helps generate patient-facing information, it aids in navigating the barriers of 'language' often innate in the healthcare system—lingo, codes sets and data unfamiliar to patients—by outputting cost estimates and other materials in relatable terminology for average consumers.

Estimation tools, though developed for complex, integrated system functionality, work best when they result in simple, effective patient-friendly communications. Cost estimates, payment guidelines, statements and financial correspondence must be generated with patients, as consumers, in mind. Complicated jargon, unfamiliar phrases or trade-leaning terms will disrupt the move toward better patient relations. Similarly, technology created for use by patients, i.e. - online pay portals, etc., should be configured in keeping with other popular web-based payment and tracking tools for patients, to ensure ease of use.

To that end, estimates presented to patients should be fully transparent and provide only the pertinent information to inform while not inundating with unnecessary details. As a matter of fact, the estimates themselves are generated upon only a few core components: historical claim payment data, provider contracts and current patient and benefit accumulator information from payers. Patients who understand the costs of what's to be done, the percentage or amount their insurance will cover and the portion of costs they're required to pay, as well as the timing for expected payment, are generally in a proactive position to address financial responsibility for their care.

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Providers Adding a Human Touch to Address the Patient as a Consumer Factor

The tangibles of a patient estimate must align with the training of the staff presenting it. New technology and estimation tools are not answers unto themselves and are only as effective as the provider staff who are using them. The human factor is at the core of a consumer-directed healthcare system.

Many healthcare providers are already addressing the human factor as it relates to the developing retail environment in healthcare, and naturally, the revamping of patient point of access is a primary focus. In days past, the role of frontline staff who directly interfaced with patients was often perceived as administrative and functional and the registration process was benchmarked for quality based on accuracy and length of time. Today, the role of frontline personnel is multi-dimensional and accepted as having greater impact to the entire patient experience and revenue cycle management process. Registrars are being trained as patient financial counselors, equipped with stronger communication tools and armed with new estimation technology as well as broader knowledge of the full process in order to provide better service, one-on-one interaction and guidance to their patients.

From the Point of Service, the Point is the Care

Well-informed patients who are not overwhelmed by costs or confused by coverage are poised for positive, less stressful encounters all around. With advanced technology and estimation tools, providers can communicate patient financial responsibility and collect payments at the point of service, enabling the focus to stay on patient care from the beginning. And in anyone's estimation, that's how the system should work.

Emdeon is a leading provider of revenue and payment cycle solutions that connect payers, providers and patients to improve healthcare business processes.

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EMDA1010267 rev 12.09