Finding and Fixing the Leaks in Your Hospital's Revenue Cycle

As healthcare costs outpace commercial and government reimbursement rates, and as high-deductible health plans become the norm rather than the exception, many hospitals have found their revenue cycle infrastructures have sprung unexpected leaks.

For insured patients, management consulting firm McKinsey & Company estimated the rate of bad debt is increasing at well over 30 percent each year in some hospitals. Consumers with high-deductible plans pay more in healthcare costs than employers and payers, and as a result, hospitals and health systems are faced with a critical payer group from which payment has proven significantly more difficult — and more expensive – to collect.

Like updates to old plumbing, full revenue cycle system replacement can be both enormously disruptive and expensive. This is enough to deter hospital leaders from making necessary repairs to fix the leaks. In the meantime, small but persistent revenue cycle leakage from insurance denials, underpayments and missed eligibility have led to substantial losses for many healthcare entities.

To stay financially viable amid the turbulence of healthcare reform, hospitals and health systems need to shift backend revenue cycle tools and processes to the patient at the start of the encounter, and stop revenue cycle leaks before they start.

The Rise of High Deductible Health Plans

Today, nearly 25 percent of employees are enrolled in high-deductible health plans, according to Mercer. The financial burden for those with high-deductible plans has significantly increased over the last decade. Kaiser Family Foundation reports the average annual out-of-pocket costs per worker rose almost 230 percent between 2006 and 2015.

As more policyholders choose high-deductible plans with increasingly larger out-of-pocket maximums, more insured patients have reported financial duress due to unaffordable medical bills. Kaiser Family Foundation found even among Americans with insurance, 20 percent had difficulty paying medical bills in the past year.

While the majority of uncompensated care is still associated with the uninsured population, a 2015 analysis by Crowe Horwath found consistent growth in the share of uncompensated care associated with the insured. The proportion of total uncompensated care associated with the insured population increased sharply from 2013 to 2014, with bad debt and charity rates rising 22 percent and 130 percent, respectively, in Medicaid expansion states.

This trend is expected to continue, if not accelerate, in the coming years. According to Kalorama Information, patient out-of-pocket spending totaled $416 billion in 2014 and is expected to reach $608 billion by 2019.

The Cost of Patient Collections

As the financial burden for medical bills shifts from payers to patients, hospitals are spending more money and time collecting medical payments from patients. A recent report by the Consumer Financial Protection Bureau found medical debts accounted for 52 percent of debt collection actions that appeared on consumer credit reports in 2014.

The cost to collect from a patient is materially higher than it is to collect from a payer, and those costs increase as accounts age on the back-end of the revenue cycle. According to a 2015 survey by Black Book, 83 percent of hospitals outsource collections to a third party. Typically, secondary bad debt collectors charge services fees between 25 to 30 percent on revenue recovered for hospitals.

Though most of the healthcare industry recognizes the importance of patient collections and the challenges it presents, point-of-service collections remain an un-

derutilized strategy. Only 35 percent of hospitals collect prior to care, representing just 19 percent of patient-owed fees, according to a 2015 report from Availity.

Self-pay accounts are expensive to collect and insurance coverage often flies under the radar. As self-pay responsibility for insured patients increases, healthcare providers need to update their collections approach to make their revenue cycle more efficient.

Why Hospitals Miss Coverage

"The biggest place where hospitals are losing money is in designating accounts as self-pay that in fact qualify for federal or commercial coverage," says Johnathan Wester, group vice president, revenue cycle management for TransUnion's healthcare division. Between 1 and 5 percent of all accounts written off as uncompensated care come from patients who are eligible for coverage.

Hospitals can miss patients' commercial coverage and federal eligibility for a variety of reasons. Emergency medical visits are urgent and unscheduled, with little opportunity for hospitals to verify patients' eligibility or demographics before treatment.

Some patients may not even be aware that their demographic or disability status qualifies them for federal coverage. For instance, of uninsured children who qualify for children's Medicaid coverage, the parents of nearly half of those children are unaware their child qualifies for benefits, according to a 2016 Medica Research study.

Medicaid expansion has further exacerbated hospitals' challenge of capturing retroactive eligibility. Medicaid coverage may be effective retroactively for up to 90 days before a patient applies for coverage, meaning patients who identified as self-pay at the time of care may have billable coverage within the next three months.

Hospitals can bill Medicaid for services during that 90 day time period, but this

process is often done manually and hospitals end up losing reimbursement for care during that window. In states that expanded Medicaid, approximately 8 percent of hospitals' uncompensated care costs are attributable to missing retroactive eligibility, compared with 3.5 percent of uncompensated care costs in hospitals in states that have not expanded Medicaid.

While many hospitals already devote significant efforts and resources to improve coverage discovery processes internally, many can benefit from the added support of a third party.

Boutique Healthcare

"Healthcare is one of the last remaining industries that provides services to consumers without requiring any payment upfront," says Jonathan Wiik, principal for revenue cycle management at TransUnion Healthcare. But in the next three to five years patients will realize the financial stakes involved in their insurance coverage and medical treatment. A more consumer-minded populace will shape the healthcare landscape into one of "boutique medicine," where patients will demand increased financial clarity to more easily shop for their care.

For now, consumers are slow to adopt new behaviors when it comes to choosing care providers. According to Castlight Health, only 1 percent of households said they used price tools to search for imaging services, 3 percent searched for lab services and 20 percent searched for office visits.

To help patients think about medical treatment in financial terms, "hospitals will need to act more like banks or car salesmen, with the tools to determine what consumers can afford, and then offer an array of financing options to help consumers make those payments," says Jason Lerch, principal of healthcare solutions at TransUnion. Tools that assess a patient's propensity to pay enable hospitals to engage patients in financial discussions that are both compassionate and productive.

Moving Back-End Processes to the Front

TransUnion gives hospitals the tools to be proactive at the front end of their revenue cycle.

eScan, an insurance discovery solution from TransUnion's healthcare division, is designed to increase efficiency in the billing process by identifying patient eligibility for Medicaid, SSI, Medicare, TRICARE coverage and commercial insurance benefits at the time of discharge.

By discovering payer coverage on day one instead of day 60, hospitals can avoid the myriad of ancillary costs associated with patient collections, including labor costs, paper billing expenses and third party collection fees. Hospitals that deploy eScan early in the revenue cycle have seen a dramatic drop in days in accounts receivable, uncompensated care and collections costs.

eScan can also help hospitals recover leaked revenue by finding secondary payer coverage. Currently, most hospitals do not have secondary payer discovery capabilities, and captureable revenue slips through the cracks.

In some cases, hospitals may unknowingly charge secondary payers for the primary reimbursement amount not knowing a primary payer exists. Often a hospital is not informed of their mistake until well after the submission deadline expires for the correct payer, losing out on total reimbursement altogether.

TransUnion's eScan solution enables provider organizations to actively rectify billing and submission mistakes because it delivers secondary coverage discovery within 60 days of patient discharge.

Checking for retroactive eligibility can present a near impossible feat for large hospitals that provide care for hundreds of thousands of self-pay accounts each year. eScan alleviates this burden by automatically scanning each self-pay account for two full years after care is provided in case coverage becomes available.

eScan has already saved individual hospitals millions in combined operational costs and recovered revenue. As of December 2015, the eScan solution recovered more

than $1 billion in total reimbursement recovered for its hospital clients. Total revenue recovered continues to grow at about $100 million each month.

TransUnion's ClearIQ solution helps hospitals determine patient out-of-pocket costs prior to care, so providers can help patients prepare financially. ClearIQ also meets growing consumer demand for increased price transparency in healthcare. It analyzes historical charges, payer contract terms and payer benefit levels to predict what patients are likely to owe for services provided. The payment estimator then offers a credible, printable and customizable letter containing patients' demographic, benefit and payment information.

While these technological solutions help prevent revenue leakage by automating tedious manual tasks, hospitals will see added benefit by making patient education a priority. If patients don't understand their financial responsibilities, they are less likely to pay on time or at all. By providing accurate cost and coverage estimates to a patient before services are rendered, patients become more invested in their healthcare and are more likely to fulfill their financial obligations while feeling good about doing so.

Mr. Wiik reinforces this. "Shifting back end processes to the front of the patient experience will offset bad debt, uncompensated care, and enhance the patient experience," he says. "A patient's first and last experience with a hospital often revolves around accounting, which is complex and confusing for many. In my experience, I have had patients actually thanking me for having financial discussions in advance of care. I needed the tools and processes in place to have these discussions, as did the patient."

The Bottom Line

Is your revenue cycle leaking reimbursement? Proven tools are available that can be used to prompt candid and productive financial conversations with patients at the point of service. Providers that are capable of recognizing and securing collections on day one of the revenue cycle see the results reflected in their bottom line. ∎