Minimize leaks. Maximize the patient dollar.

To improve cash flow and ensure care is proactively funded, you’ve got to minimize revenue leaks.

Drip. Drip. Drip. Stressed and overworked healthcare revenue management platforms are like old leaky pipes. Bad data clogs the system, and cracks in the manual processes cause profit to slowly seep out through every stage of the revenue cycle. When left in disrepair, revenue cycle leakage from insurance denials, underpayments and self-pay collections lead to substantial loss. While it’s not always possible to replace an entire revenue management platform, manual efforts to patch trouble spots here and there are time consuming, and they rarely make a major impact. So what can you do to stop the leaks?

Do as much as you can on the front end. Healthcare organizations can improve cash flow and prevent bad debt on the back end by eliminating guesswork from the revenue cycle.

Remember, the industry is changing dramatically in the face of consumerism and healthcare reform. As active consumers, patients scrutinize each experience, look at bills more closely, and prioritize payment based on perceived value. Yet, the majority of patients still don’t read their insurance policies, understand their coverage, or realize why they have to pay so much with their high dollar deductibles – which can financially devastate them. This adds a behavioral aspect to collections that has not necessarily existed in the past. Because of this, it is imperative for healthcare organizations to be transparent with the revenue cycle if they want to efficiently collect more.
Keep the pipes clear: Be transparent and cash will flow.

Think about this: healthcare is one of the few industries that still allows consumers to get what they want without paying a dime up front. It’s not uncommon for patients to receive their first bill weeks after service. By that time, they are harder to reach and completely disengaged – and likely less willing to prioritize a healthcare bill over mortgage or other debts. No wonder cash flow becomes an issue! This paradigm must shift.

Estimation tools can help. Providing pre-service estimates to patients gives providers an opportunity to set expectations before services are rendered. A good estimator clearly outlines predicted charges for which a patient will be responsible, taking into account historical expenses, payer contract terms and patient benefit levels. When such information is readily available, providers are able to review the amounts due from patients, collect a portion of each bill at the point of service, and discuss payment due dates going forward.

Not every estimation tool is the same, though. The scope, accuracy and deployment cycle can vary, so it is important for providers to understand the capabilities of the specific tool they are using in order to have accurate discussions with patients. The best estimators not only consider the numerous fees associated with every portion of a procedure (doctors involved, lab work, medications, etc.) but also insurance deductibles and co-insurance to more accurately predict costs. For example, a patient who has already met his annual deductible will have a different projected balance than a patient who has yet to make a claim during the plan year.

“Without an estimator, hospitals have larger collection costs because they didn’t collect anything up front. That will translate to a lot of bad debt, denials, and stoppages in revenue cash flow because patients haven’t been appropriately screened financially prior to onboarding services. They are disengaged and disinterested in funding their care. It is so unique in this crazy industry.”

– Jonathan Wiik
Principal of Revenue Cycle Management
TransUnion Healthcare
Fill the gaps: Get to know patients and reduce uncompensated care.

Understanding whether a service is covered and how much a patient will owe for service is important. However, even more important is to understand each patient’s ability to pay and the timeframe in which the debt will be settled. This can be challenging because often patients aren’t completely aware of their own financial situation or how healthcare bills will affect them. Relying solely on a patient’s word, or an inefficient estimator, will lead to trouble.

Most hospitals are currently using some kind of estimator solution, but it is likely that it is segmented and only does a few things well. Wiik noted, “The three biggest ‘buckets’ CFOs are trying to fill are functionality in stopping the leaks, the cost of the tool and integration to other systems. To efficiently reduce uncompensated care, find a platform that meets all your needs at the right price, and that integrates as much as possible.”

Automated solutions simplify this process and provide great insight into each patient’s financial situation. Efficient screening tools can quickly verify demographic and identity data, predict propensity to pay, identify potential coverage issues, and determine a patient’s overall ability to pay. With this information, Wiik suggested that the provider “can stratify patients in to high-risk, medium-risk, and low-risk categories. You can’t talk to every single patient and get what you need, especially if they’re in your Emergency Department at 2 A.M., but if it’s a knee surgery scheduled next Tuesday, for example, you can work with that and be very effective.”

By receiving this information early, the provider can create reasonable payment plans and concentrate efforts on those who are at greater risk for default. If needed, additional screens, like federal poverty level and charity-care eligibility, can be run to aid in the search for alternative payment sources.

The more time providers have to collect information and make a thorough analysis, the better. Screening should begin at the time an appointment is made. However, even in emergency or walk-in situations, these tools encourage more comfortable, better-informed decisions for you and your patients. It becomes a partnership, clinically and financially.

Screen and stratify patients up front to:
• Reduce claims denials and data entry errors
• Prevent identity theft
• Increase revenue recovery
• Standardize charity care determination processes

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Developing patient advocates can:

• Improve patient satisfaction
• Increase workflow efficiency
• Decrease the likelihood of payment default

Patient expectations are on the rise. Perceptions of quality can be altered completely if one hiccup occurs during the patient experience. Patients are not afraid to share healthcare nightmares with everyone they know. Those stories are impacting revenue reimbursement more than ever.

According to the Center for Medicare and Medicaid Services, more than 1% of Medicare reimbursement to hospitals is now based on whether or not patient experience standards are met as reflected in Healthcare Consumer Assessment of Health Plans and Systems (HCAHPS) surveys. “Previously, patients rated hospitals on whether the food was cold or the people were nice,” said Wiik. “Now, because they are consumers, not just patients paying a co-pay, they are valuing the services received based on the money they put into it.”

One of the most frustrating (and perception-altering) factors for many patients is that the first and last encounter they have with a hospital is about billing: “Welcome, can I have your ID and insurance card?” Shortly followed by an impersonal and unexplained, “Here’s your bill in the mail.”

To avoid dissatisfaction, hospital representatives need to understand how to use revenue cycle tools effectively and to speak eloquently and compassionately about the information generated. “Forward-thinking, transparent conversations about cost rarely happen on the front end or before services are given,” said Wiik. But by positioning themselves as helpful advocates, staff can change this trend and lead these conversations – and be thanked by the patient in the end.

More often than not, patients appreciate being included in these open dialogues early in the process. It gives them the opportunity to ask questions and clarify their obligations to avoid future surprises. The consultations may also generate more positive feelings, as patients begin to trust that the provider is doing everything possible to help them, not only clinically, but financially as well.

Reinforce connections: Be compassionate to improve satisfaction.

The bottom line.

Fixing leaky revenue cycle pipes is something that cannot be put off. They need to be repaired immediately in order to avert disaster. The same holds true for underperforming revenue management platforms. While it may seem overwhelming, providers shouldn’t try to plug leaks in the revenue cycle on their own.

Great tools are available that can be used to prompt candid conversations with patients at the point of service. Together, both parties become more educated about costs, coverage, and opportunities to pay. Providers are able to collect more money up front and recognize alternative payer sources more quickly. Patients become more invested in their healthcare and are more likely to fulfill their financial obligations, while feeling good about doing so. All of these improvements can lead to enhanced cash flow and a reduction in losses from uncompensated care.

This special report is brought to you by TransUnion Healthcare, whose estimator solution, ClearIQ, can provide your staff with the smarter decisioning power. ClearIQ is an exception-based decisioning platform driven by TransUnion’s unequalled data assets and industry-leading eligibility, estimation, and collection functionality. ClearIQ provides healthcare providers with Intelligence in an Instant® - the power to make informed, consistent patient access decisions at the point of service.

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