MAXIMIZING REVENUE AND RELATIONSHIPS IN THE AGE OF PATIENT CONSUMERISM

Maintaining financial stability is a challenge for any healthcare provider's office, but especially in the industry's current age of patient consumerism.

The increases in regulation and the transparency of medical care processes have given rise to healthcare consumerism, wherein newly empowered patients have control over their healthcare experience.

Along with shifting reimbursement strategies and the increased demand on patient financial responsibility, improving your bottom line has become even trickier.

Every station in the revenue cycle has room for improvement, and it's difficult to keep those processes efficient and optimized for maximum recoveries in conditions of continuous change. Whether you're trying to appeal to the healthcare consumer, collect more data from patients, process insurance claims more proficiently, or collect patient revenue, this article identifies the current challenges facing healthcare providers, and then offers several modern solutions to maximize revenue collection with the healthcare consumer in mind.

Higher Demands on Patients, Less Revenue Recovered

First, let's identify the challenges. The rise of patient consumerism has placed heightened responsibility on patients, both in terms of their access to healthcare information and their financial obligations.

Patients, empowered to shop around for the best deal given the upsurge in their out-of-pocket costs, now demand more from their healthcare providers. They have new information at their fingertips thanks to healthcare websites and consumer feedback mechanisms, and their awareness through a relatively recent push toward patient education has enabled them, in a sense, to take control of their own patient satisfaction. They expect better service, and when they don't receive it, they take to consumer feedback sites or simply shop elsewhere. This can affect your patient inventory and loyalty.

Elsewhere, due to the increase of high deductible health plans, a significant chunk of the healthcare office's revenue now falls on patients, and that number will only continue to increase in the foreseeable future. More than three-quarters of healthcare providers reported that patients have experienced a rise in patient responsibility, according the Jacqueline LaPointe, writing for *RevCycle Intelligence.*

With the increase in patient payment responsibility, the amount written off by healthcare offices has increased as well. In fact, LaPointe writes that providers often expect to collect only 50 – 70 percent of a patient's balance after a visit. And Modern Healthcare predicted that 30 percent of patient responsibilities, around $200 billion, will be written off by 2019 due to the increased need to recover accounts directly from patients.

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The shift toward patient responsibility also means additional denials for insurance coverage. Eligibility and missing or invalid claim data are the most common reasons for claim denials, which prevent timely reimbursement and eat into your bottom line. And the appeal process can have a high price tag, albeit unseen, given the administrative expense to carry them out. Change Healthcare provides some insight, estimating that around 9 percent of claims are initially denied, and only 63 percent of denied claims are recoverable. Meanwhile, the administrative cost of following up on a denied claim averages at $188 per claim, taken from over 3 billion hospital transactions.

So just to summarize: Now you're dealing with patients who demand better service and yet have a higher deductible, and therefore have a higher likelihood of nonpayment, which is only augmented by the frequency of insurance denials, meaning less revenue recovered by your office.

HOW YOU SHOULD RESPOND

Healthcare providers, hospitals, clinics, and single-practice doctors have tried a number of solutions to resolve or at least lessen the impact of these issues. Most healthcare enterprises have sought to make enhancements to the stations along the revenue cycle. Here are five areas of improvement that can require attention to maximize recoveries:

1. More Information Leads to Better Recoveries

Gathering accurate information from patients is a vital aspect to getting paid. The general rule is, the more data you gather, the better.

Even though the patient registration process can be difficult in the busy office environment, an accurate patient account with detailed contact info, medical history, and insurance information will lead to a better rate of payment. For instance, beyond the usual information, get a secondary email, alternate numbers, and more than a single alternative contact person.

To avoid spending too much of your staff's time on these data-gathering administrative tasks, many providers rely on pre-registration software to ensure a patient's in-office visit isn't bogged down by tiresome informational questions. In this sense, preregistration also improves the patient experience by making the office visit less time-consuming.

Preregistration, particularly in an online form that patients can fill out in their own time, will also allow you to ask additional questions about their health history and orientation that would take up too much time in the office. Having and reviewing this information in advance of their appointment will also help you determine their insurance coverage, which will better prepare your staff when the time comes to propose an accurate account of available treatment plans and costs.

2. More Clarity

Clear communication throughout the revenue cycle is generally a good policy. But the majority of providers have not made clear communication about patient billing a priority. For instance, only about 20% of hospitals have sought to better educate patients about their bills, according to *InsideARM*.

At all times, your friendly and knowledgeable staff should be crystal clear about how to determine the costs of treatment, as well as how to cover that information with the patient. Understanding that patients now must commit more money from their pocket toward their healthcare bill, your staff should approach patient communication as an investment toward getting paid. Best of all, improving patient clarity around the costs of services will improve recovery rates.

If providers take the time to communicate the cost of medical care before a procedure, they ensure that patients are aware of their obligations. After all, given the rise of patient consumerism, the transactional quality of healthcare requires that offices take steps to ensure both parties involved in the transaction are cognizant of the financial responsibilities.

Financial assessments with the patient, especially those with larger balances, can determine how much their insurance will cover; and for those without coverage, detailed financial discussions to explore options like Medicaid or even hospital charity programs.

Later, provide clarity about outstanding balances, and discuss the potential for payment arrangements, which you should tailor to suit the needs of individual patients. The more flexible you are for patients in difficult financial situations, the more likely you are to get paid.

3. Better Service

If the healthcare industry is to meet the challenges of patient consumerism, providers must improve the patient experience with high-value healthcare. This means some serious empathy is in order. High-value healthcare is everything from avoiding one-size-fits-all payment plans to improving your bedside manner through active listening.

In the age of patient consumerism, the old school consultation in which doctor knows best is a thing of the past. Today, providers are moving toward a shared decision making process between patient and provider. "We used to tell them how they're doing. Now, they're telling us," said Judith Baumhauer, MD, MPH, associate chair of the Department of Orthopaedic Surgery at the University of Rochester Medical Center (URMC), in a recent interview with the Healthcare Financial Management Association (HFMA).

According to Lola Butcher with the HFMA, one method used by providers to deliver better service are patient-reported outcome measures (PROMs). PROMs give the patient control over their healthcare, allowing them to make choices based on costs, pain levels, or the invasiveness of a procedure—all factors that could have an effect on whether a patient pays down the road.

Essential to the PROMs process is active listening, which "has been shown to reduce the nation's healthcare tab," wrote Butcher. The specific use of PROMs has had a slow integration into the healthcare community, however, as Butcher's article suggests, less than one percent of patients experience their providers using PROMs.

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Nevertheless, providing hands-on service will engender a feeling of loyalty with the patient, which will decrease the likelihood of a patient becoming past-due. Patients who are satisfied by their experience are 74 percent more likely to pay when the time comes.

4. Commit to Faster, More Accurate Claims Processing
During the claims submission process, many problems can arise that will slow or altogether halt payment. If your office has a proficient, preferably electronic claims submittal process, you can maneuver the hurdles with maximum efficiency, ensuring your revenue isn't lost in claims limbo.

When it comes time to fill out a claim form, your organization's coder(s) must correctly log the ICD-10 code to ensure that the code is accurately submitted. Ensuring accuracy prevents undue claims denials, and an electronic submittal form limits the possibility of errors through systemic catches. After the claim form is submitted, it's sent to private or government insurance for reimbursement to pay for covered services. And it's up to your billing office to recover any amount not paid.

Because this process can take weeks or even months to resolve all coverages, denials, resubmissions, and payment, patients rarely have the chance to plan financially for their due amount. This is why it's so important for healthcare offices to talk with the patient beforehand about billing. A speedier claims submission process is an important supplement to the clear communication previously discussed.

5. Automate the Recovery Process with a Patient-Friendly Collection Partner
Following the four above best practices can help reduce the need for collections. Still, providers will discover that no matter how much they improve the patient experience, a certain percentage of patients will still end up past-due. The services of a trusted collection partner, one just as concerned about the patient experience as you are, becomes a crucial component to your revenue cycle.

Some providers have tried to combat this by adding members to their billing staff. However, the effective recovery of a past-due medical bill isn't easy. Several hospital systems have experienced backlash from patients and regulators like the Consumer Financial Protection Bureau (CFPB) due to their staff not following correct procedures during the collection process. A slew of federal and state-specific laws mandate what a bill collector can say and must do when talking to a past-due patient. For example, there's the Dodd-Frank Act, which prohibits both service providers and covered entities from committing Unfair Deceptive Abusive Acts and Practices (UDAAPs)—practices that mislead, cause injury, cause confusion, or take advantage of consumers.

If those regulations, designed to protect consumers, are broken during the collection process, the consumer can sue. Thousands of patients have filed complaints with the CFPB against hospital systems taking unlawful action to collect delinquent accounts, and some have resulted in lawsuits against those systems. Many hospitals, and even collection agencies, ignore or are simply not well educated in the various collection regulations. In the age of patient consumerism, this can have a negative effect on a healthcare provider if they receive a high volume of complaints.

Additionally, the patient experience is just as important at the collection stage. A collection partner only concerned about their recovery rate, and not enough about providing a positive patient experience, could ruin the hard-won relationship you've established with your patients. In the age of patient consumerism, the occasional past-due patient has become more commonplace. And so, you need to concern yourself not only with getting paid in the event of a past-due account, but maintaining a healthy ongoing relationship with your patients to ensure they return to your office after they resolve their past-due bills.

If you're looking for a collection partner, be sure to evaluate their staff for call quality and empathy training. Gone are the days of Moose and Rocko knocking on patient doors to recover a debt. Following the guidelines set forth by regulators, collection agencies should train their staff to recover healthcare debts in an ethical, compassionate way. Collection representatives should be attuned to the patient's situation, adopting the tone of a financial counselors or customer service agent—not the aggressive tone one imagines when they typically think of a collection call.

Besides a patient-friendly staff, a collection agency should be able to connect with your practice management system. Creating a seamless, secure connection with your collection partner will streamline this step of the revenue cycle process, eliminating the need for manual entry, while decreasing the likelihood of a dispute by ensuring accuracy. And your staff will save time because they can submit debts to the agency automatically and not have to make collection calls, which is something they may not be trained to do effectively. This degree of seamless integration also means you can report payments instantly, the patient's account is resolved faster, and you get paid sooner.

Surprise!
Patient Consumerism Leads to Financial Security
Consumers who are empowered and more engaged in their healthcare financials have led to a better patient experience, but they have also resulted in challenges for every healthcare office. Even so, patient consumerism shouldn't be thought of as a burden because it requires healthcare organizations to update their revenue cycle processes. Through these changes, more people have a positive experience, which is a good thing. By updating the suggested areas of the revenue cycle—creating efficiencies, improving communication, delivering better service, and having a trusted collection partner—you can supply a better patient experience. The result will be a loyal consumer base, which will naturally maximize your revenue in the age of patient consumerism.