The New Rules of Revenue Cycle: Adapting in an Era of Change

The way Americans pay for healthcare services is changing—and so are their interactions with providers. Healthcare organizations will be taking on new or expanded roles as benefits educators and administrators, financial counselors, creditors, and collectors. HealthLeaders Media recently convened a panel of experts to discuss how healthcare reform, insurance industry trends, consumerism, changes to reimbursement, and emerging care models will affect revenue-cycle management. The solutions they propose range from better use of data and technology to building better relationships with patients—especially when it comes time for them to pay the bill. Following are highlights from that conversation.

PANELIST PROFILES

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Vice President of Revenue Management
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HealthLeaders Media
**Roundtable Highlights**

**HEALTHLEADERS:** How will healthcare reform affect revenue-cycle management? What role will technology play?

**DEBORAH LELINSKI:** Healthcare reform is driving the movement to high-deductible health plans. The rise in self-pay alone is going to demand more interaction with patients about their ability to pay before they receive treatment. Technology can make this conversation between the healthcare provider and the patient easier, more streamlined, and lead to prospective payment arrangements that are satisfactory to both the provider and the patient. Technology will also bring greater efficiency to the revenue process. We can’t continue to work in a manual fashion. We don’t have enough FTEs to continue to do revenue work as we do it today.

**TIMOTHY J. REINER:** As much as I want to say the solution is to hire more people, I’m not sure that’s where we need to go. The answer will be to invest in better technology, faster technology, more accurate technology. It’s going to be connectivity not just with the payers, but, in regard to the ACO model, with everyone. Where does that patient fit into the whole continuum? What is the benefit structure like? And how does each of those visits they’ve had throughout the continuum with different-level providers impact what they owe you when they are there in front of you—or hopefully, before they present or when they schedule. Can you accurately calculate it? Can you efficiently collect it?

**THOMAS YOESLE:** It’s challenging from a patient education perspective: telling patients why they owe more money than in the past, interpreting new rules, helping patients into the right programs, and helping them understand those programs.

**RICHARD O’DONNELL:** Insurance exchanges could take that role of interpreting benefit design. They’re going to define what’s gold, what’s silver, what’s bronze in terms of out-of-pocket liability, and that’s going to have a huge impact as to how people choose a plan and what level of personal liability they want to assume. That has implications for the providers in terms of collectability.

**REINER:** But we’re still going to have to engage the patient in different ways once those exchanges become more prevalent in the various states in 2014. It may be online portals or other strategies. There is a lot we don’t know, but clearly one of the tenets of meaningful use is to engage the patient more online in their care—including their financial responsibility.

**YOESLE:** As much as I want to push this education and information to the Web, I think we’ll start hosting workshops and using kiosks to answer questions about benefits and plans and then push those FAQs to the Web. Right now, that education is happening over the phone in the centralized scheduling area.

**LELINSKI:** Technology can play a huge role in helping consumers understand their plans, their benefits, and the amount they must pay out of pocket. Once I, as a consumer, have that information, I’m going to go where I can get the best deal—the best quality for the best price. Right now, it’s very difficult to realistically predict the cost of service when the complexity leads us to answer with “It depends.”

**REINER:** Estimating benefits is something that we’ve struggled with from the Stone Age. As a provider, you’ve got to decide whether to invest in additional technology beyond just pushing a button and sending a transaction to the payer or screen scraping [capturing computer screenshots and putting them into a database]. We should be so much better than this.

**O’DONNELL:** We need what I would call real-time patient liability estimators—complete interconnectedness between health plans and the clearinghouses and the providers. Let’s allow the patient in this brave new world of consumerism to go into their own portal through the provider, get to their data, and pull back what their unmet liability is. And it’s still not 100% certain, so we put disclaimers all over it. But it’s so much better than having someone asking 20 questions to identify your possible out-of-pocket liability that may still be inaccurate.

**YOESLE:** It’s a failure of both providers and payers that we haven’t opened this up as a Web service.
ROUND TABLE: THE NEW RULES OF REVENUE CYCLE

**HL:** How will health plans that shift more of the cost to policyholders affect patient utilization?

**O’DONNELL:** Honestly, I think we have to categorize the impact of healthcare reform on patient utilization as a great unknown. Any actuary that walks in and tries to convince us that they can anticipate the impact is wrong. With consumer-directed health plans, the actuaries advised the insurance industry on premiums and product pricing based on anticipated utilization and out-of-pocket costs. And I don’t believe a lot of those predictions came true. In fact, consumer-directed health plans faded into history.

**LELINSKI:** There is a hypothesis that the financial burden placed on consumers through high-deductible plans will hinder quality outcomes if patients put off a test or don’t fill a prescription, for example, because they’re paying for it out of pocket.

**O’DONNELL:** The question is, are you going to shop for total price on a higher-level service with the same zeal that you might with a thyroid scan? As the complexity of the service expands, I think the consumerism piece fades back.

**HL:** How will collaborative and accountable care models affect revenue and collections?

**O’DONNELL:** I have this hypothesis, though may be proven terribly wrong, that you have a much better chance of collecting out-of-pocket liability when there is a longitudinal relationship between the patient and the provider. Primary care physicians have better luck with collections than a hospital or a subspecialist. In an accountable care organization, though, since we are attributing patients to providers and they are being encouraged to stay within a coordinated care environment, you are creating more of that longitudinal relationship between the patient and a set of providers. We need to build off of that and take advantage of that relationship.

**YOESLE:** In the ACO and the medical home models, one of the intents is to have more communication with your primary care provider. And the medical home could be where you collect for primary care, specialist, and hospital payments. How do you work on those relationships? Because now I have to build a relationship not just with the patient but with the office manager of that medical home that we just partnered with and say, “Hey, by the way, can you collect on our bills, too? Because the patient likes you more and will respond better to you than they do with me in the ED when I’m constrained by EMTALA laws.” So maybe that’s a collection methodology, and we give them access to our collection and patient accounting system.

**LELINSKI:** I’m also excited about the concept of patient relationship management. How do you drive the highest possible chance of obtaining payment? It has to do with the relationship. Our statistics and our customers’ statistics show that you can establish a relationship if you know the patient’s total debt picture and how that impacts his or her ability to pay. You can make accommodations to renegotiate the payment plan, for example. Another important piece is obtaining that promise to pay.

**REINER:** I’m much more interested in collecting payments at the time of service than scoring it at a later date or getting promises. To the degree that a patient can’t pay in full at the time of service, we do allow them some flexibility but create less risk for ourselves by creating a secured payment plan. We take their credit card or checking information and charge them each month. The only way they can get out of that promise is to cancel the credit card or close the bank account.

**O’DONNELL:** We need to come to an understanding that seeking payment at time of service is not at all inconsistent with our mission. But there’s a huge conflict in the industry with key individuals who still don’t know that and believe that it’s incompatible to ask for payment at the time of service. I don’t know of any other industry that gives a pass to the consumer.

**LELINSKI:** And other medical services don’t. You never go into an orthodontist or a dentist without paying 50%. Our industry has to push through the discomfort of asking patients for payment and establishing a realistic plan for meeting their obligations. Helping patients understand their liability

**YOESLE:** Presumably that risk is going to be on the payers and the exchanges. They’re going to have to intervene more to mitigate the risk. Will a $100 private insurance copay for an urgent care visit discourage someone from going? It might. It may drive up the cost of overall care. But that’s going to be the private payer’s problem because they took on the risk.

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before they receive treatment is more humane and respectful than surprising them after the fact.

**HL:** What are the advantages and disadvantages of outsourcing patient payments?

**YOESEL:** More and more companies are offering a centralized insurance verification, scheduling, and precollect service. You can tell them exactly what you want to collect and how to collect it. You can tell them which funding programs to offer and which patients to say no to. When the administrator calls you and complains that someone couldn’t get in to get a chest x-ray, you can say, “Oh, it’s that darn company that we outsourced to, you know, they’re really strict. But look, our net revenue is up. Our preservice collections are through the roof. We didn’t even hit $10 million last year and we’re up to $12 million halfway through this year. Wow, what do you think about that?” Outsourcing lets you offer your patients a myriad of options, and it’s more cost-effective than you could ever be.

**REINER:** I don’t think we can abdicate that patient interaction. Then someone else is running our network, aren’t they?

**YOESEL:** Yes.

**REINER:** If we abdicate that responsibility, we’re no longer running our own network or making decisions about where the patients go, where they get scheduled, how they get scheduled, and I just don’t think that CEOs will want to do that.

**O’DONNELL:** It’s also a big patient satisfaction risk. I know some healthcare providers that have outsourced and have actually chosen to go overseas. It’s a huge dissatisfier.

**HL:** How do you balance customer relationships, your image, and your mission with the need to collect payments—especially when an account goes into collections?

**YOESEL:** When you sell your debt, it’s up to you as a provider to contractually protect those patients. Because what you’re selling is liability, and you’re selling accounts and you’re selling paper. What you’re not selling are people and patients. Those patients are going to come back to you as a provider. It’s up to us to tell your debt buyer that, for example, they can’t resell or file a judgment without prior approval. Now that’s going to cause your collection rate to plummet. You have to balance that protection with how much cash flow you really want.

**O’DONNELL:** There is another leverage point, and that is the health plan itself. If plan members signed on with high deductibles but then are defaulting on those deductible payments, we need to go after the health plan the next contract cycle. We can impact their discount to recoup those dollars that have now gone to bad debt. Now there’s a bit of negotiation that has to take place, but we’re sending the message to payers that this is their responsibility because they’re selling the benefit design. This is how they’re getting people in the door, how they’re getting employers to sign up with their plan. They’re reducing the employers’ costs, but if we’re at the end of the food chain, then that’s going to have ramifications for the health plan or payer.

**HL:** How will new payment models, such as value-based purchasing and bundled payments, affect revenue and collections?

**O’DONNELL:** I’m not bullish on whether bundled payments are even going to materialize. They’ll be tested, there will be some pilots. I’ve seen examples where commercial health plans have figured out how to drive the change they’re seeking without having to retool their entire claim processing system.

**LELINSKI:** That’s where I see capitation as more of a valid model. If you’re going to take accountability, capitation gives some potential of an upside. You can calculate the actuarial value of an insured life depending on age and other factors. It’s easier to administer.

**YOESEL:** But generally that’s not what healthcare providers do. They’re not in the business of taking risk. Insurance companies are. Asking healthcare providers to suddenly take risks—it’s not what we do. We take care of patients.

**REINER:** There are still too many providers that make money on fee for service.
In other words, why would you go backward economically on something unless you really had to, right?

**O’DONNELL:** So did we convince you that fee-for-service is not dead?

**HL:** I guess we’ll see. Speaking of which, with so many uncertainties and so many complex concepts with far-reaching implications, how do you talk to and educate leaders about these issues?

**REINER:** I’m willing to take that risk. If we made a charge capture error, we’ll take our lumps. It would be better to miss a charge but get the payment at time of service.

**LELINSKI:** Like it or not, hospitals are involuntary lenders in the same way that patients are involuntary debtors.

**O’DONNELL:** Why do we have to be involuntary lenders? When I walk out of this hotel, the bill will be paid. All charges will be captured and the account will be settled to zero. And yet in our institutions, we are involuntary lenders because we don’t capture the charge, code the claim, and send that claim off to the payer in real time.

**REINER:** We do offer interest-free financing for one year like Jared’s or Best Buy. We are a community provider that does take that covenant seriously, and so we’ve got to have an option for them. Whether we like it or not, we have become a financier or at least a facilitator of financing—somebody else services the debt, but we facilitate their application process. It’s no different than buying furniture.

**DEBORAH LELINSKI:** Director, Ontario Systems

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**O’DONNELL:** Registration folks ought to be some of the most highly valued employees—not just because of their customer service skills. Really, it’s just attention to detail. They’re picking out codes and they’re setting up the records and the entire documentation of the revenue cycle. Poor choices that are made at the front end are seen at the back end, and that affects everything that goes into the data warehouse.

**REINER:** We have to retrain them.

**YOESLE:** You can also evaluate a patient’s ability to pay and his or her ability to qualify for different payment plans.

**O’DONNELL:** We can provide the patient with a “financial navigator.”

**YOESLE:** One of the things we look for when we hire people for the call center or collections is a customer service background.

**LELINSKI:** Can you afford to compete for those skilled individuals, though? Revenue is going down, there’s competition for FTEs, a shortage of a million nurses and 900,000 doctors by 2020. And there are a finite number of capable individuals in the world.

**REINER:** There are consumers that don’t necessarily want to have a long drawn-out discussion with a financial navigator. But there are other patients that want to be walked through the process. We have to change the way we engage patients and meet their individual needs.

**YOESLE:** You talk about data and about mission. You’re balancing mission with financial education with operational education to a C-suite person, and you have four minutes to do it. It’s challenging. Discussion 101 is know your audience and what to say.

**HL:** What are some other considerations when it comes to collecting payments at time of service or securing promises to pay?

**REINER:** As we move toward more EMRs, documentation will drive the charges. If you’re documenting a level 3 evaluation and management visit, you know that by the time the patient is ready to walk out the door. That claim could be adjudicated, as with the pharmacy model, and you would know your copay is $35. There’s no reason that episodic physician visits can’t be done like that. Inpatients are a little different, but the only reason that it can’t be done is because the payers don’t offer it and there’s not a singular work flow for it. There are actually payers that do offer it now. But you’d have to have five different work flows for five different payers.

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Today, hospitals and other healthcare providers not only have to provide exceptional care—now you also have to be exceptionally shrewd with your business operations. You need solutions to improve your overall revenue-cycle, increase cash flow and improve your bottom line.

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