Patient Access

“The Big Opportunity”
Evolution of the Revenue Cycle

Over the last 10 – 15 years the industry has increased

- Awareness
- Understanding
- Recognition
Leading to.....

- Use of Key Performance Indicators
- Greater industry consensus on national average & best practice measurements
- Achievement of best practice levels
- Revenue Cycle positions established
- Internal Revenue Cycle Teams
From a Ripple to a Wave: Why Eligibility Matters

Pamela M. Waymack & Gwendolyn Lohse

Incomplete eligibility verification can create problematic ripples throughout the revenue cycle. But some healthcare organizations have found a way to keep the ripples from turning into a tsunami.

It is a simple fact of the healthcare revenue cycle; insurance eligibility drives payment. And as a first step in that cycle – eligibility verification – is the most critical. Unfortunately, eligibility verification is one of the most neglected elements in the revenue cycle.

Patient Access: A New Face For the Revenue Cycle

Michael S. Friedberg

Patients’ first impressions of hospitals are likely to improve dramatically as a result of recent breakthroughs in managing the revenue cycle’s patient access processes.

At a Glance
Patient access management requires skilled staff to fill the new role of patient representative.

Unlike registrars in the past, patient representatives must perform a diverse and complex range of tasks, including reviewing referrals, obtaining authorizations, verifying eligibility, and requesting payment at time of service.

Providing patient access staff with adequate training and ensuring they undergo sufficient quality assurance monitoring are critical steps to effective patient access management.

It is not far-fetched to call scheduling and registration processes the “face” of a hospital’s revenue cycle operations. A patient’s first encounter with a hospital’s revenue cycle typically occurs with these processes, and it is here where the patient forms his or her first impressions of the hospital. Yet for many years, the evolution of these patient access functions lagged behind that of other areas of the revenue cycle. Today, these circumstances have changed, as new developments in patient access are raising this area to new levels—and giving hospitals the opportunity to present a new face to patients.

U.S. hospitals have long used sophisticated methods and technology to manage other key revenue cycle processes. Over the past 20 years, keeping step with the increasingly complex requirements for managing coding and billing processes, hospitals have seen their business offices evolve into patient financial services, and medical records transform into health information management. Today, patient admitting and registration processes are undergoing a similar transformation as patient access management has become the latest area of focus in the development of the hospital revenue cycle—with the promise of

Patient Access Management Benefits

Patient access functions have long been the revenue cycle’s Achilles heel—with poor data collection providing a classic example of “garbage in” producing “garbage out.”

The causes of poor data collection during the registration process are well documented:

- Lack of feedback on error rates, resulting in a lack of accountability for errors
- Pressure to register patients rapidly, often at the expense of data quality
- Lack of tools necessary to accomplish the tasks required
- Complex systems that provide too many choices

Patient access management aims to eliminate these deficiencies. The improvements from creating such a department can not only have a direct impact on cash flow and operating costs, but also drive patient satisfaction.
Patient Access lags behind due to….

- Inadequate training
- Low pay levels
- High turnover
Patient Access lags behind due to....

- Insufficient Audit & Monitoring processes
- Lack of System integration & optimal use
- Minimal number best practice measurements
- Current best practice goals are too low
### Current Patient Access goals

#### Patient Access Quality

<table>
<thead>
<tr>
<th>Relevant Metrics*</th>
<th>Best Practice Targets*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician authorization compliance</td>
<td>95% compliance</td>
</tr>
<tr>
<td>Inpatient admissions error ratio</td>
<td>&lt; 3% error</td>
</tr>
<tr>
<td>Outpatient registration error ratio</td>
<td>&lt; 3% error</td>
</tr>
<tr>
<td>Point-of-Service Collections</td>
<td>Collect 50% of estimated patient portion at the POS</td>
</tr>
<tr>
<td>% of pre-registered inpatient accounts</td>
<td>40%</td>
</tr>
<tr>
<td>% of pre-registered outpatient accounts</td>
<td>20%</td>
</tr>
</tbody>
</table>

*Source: HFMA 08 BBBH August.indd
Related Opportunities...

- Increase number of patients with insurance verified prior to visit
- Increase number of patients registered prior to visit
- Increase registration accuracy
- Optimize cash collections
- Improve patient throughput
- Create a better patient experience
Opportunities Realized....
Excuses, excuses….

- Not enough staff
- Not enough time to check insurance
- Not sure of what amount to collect
- Patients don’t have the money to pay
- Do not want to upset the patient
- Systems not interfaced
"Plan for Change"

Patient Access……..A Role Re-defined

<table>
<thead>
<tr>
<th>Responsibilities</th>
<th>Then</th>
<th>Now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Capture</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Insurance Verification</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Check Medical Necessity &amp; ABN Notification</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>ID &amp; Collection of Co-pay</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>MSP Forms</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Error Tracking/Edit Software</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Reporting</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Average Pay Level</td>
<td>$9.00/HR.</td>
<td>$10.00/HR.</td>
</tr>
</tbody>
</table>

Source: RCS client database
“Plan for Change”

Training

- Scope should include:
  - Data capture procedures
  - Insurance verification
  - Registration system/process
  - Collection techniques*
  - Financial counseling
  - Forms and documents
- Comprehensive testing of trainees before assignment
- Continuing education for existing staff
“Plan for Change”

- Staffing
  - Migration of Patient Access staff for improved performance
“Plan for Change”

- Insurance Verification
  - Comprehensive insurance verification following scheduling
  - Real-time electronic insurance verification at live registration
  - Identification of patient financial responsibility and levels of coverage
Insurance Verification Improvements

Number of Scheduled Patients with their Insurance Verified

- Month 1: 15%
- Month 2: 30%
- Month 3: 57%
- Month 4: 74%

Source: RCS client database
“Plan for Change”

- Pre-registration
  - Pre-register all scheduled patients 3 days in advance
  - Obtain complete and accurate patient information
    - Demographic
    - Insurance
    - Medical
  - Notify patient of co-pay due and collect
  - Investigate other potential coverage sources
Pre-Registration Improvements

Number of Scheduled Patients Pre-Registered

Month 1: 25%
Month 2: 46%
Month 3: 67%
Month 4: 86%

Source: RCS client database
“Plan for Change”

- Registration error measurement & monitoring must include:
  - Demographic
  - Insurance
  - Medical
  - Concurrent monitoring
  - Feedback
  - Billing Software Collection/Follow-up Staff Denials
Typical Registration Errors

Sample Registration Audit

- Incomplete or Missing Guarantor information: 59%
- Incomplete or Missing Employer information: 16%
- Policy ID # is incorrect: 7%
- Missing Social Security #: 2%

Source: RCS client database
The average hospital performs approximately 120,000 non-urgent registrations annually...

- About 65% of these are scheduled
  - Less than 15% verify insurance prior to services
  - Less than 25% are pre-registered
  - Less than 2% of patient amount are collected

Source: RCS client database
Example:

120,000 Total Registrations
x 25% Applicable co-payment population
= 30,000

x $50 Average co-payment due
= $1,500,000 Total Amount Available for Collection
Dollar Impact of...
Increasing collections from 10% to 50%

Based on: Estimated 25% with co-payment due.
Average co-payment of $50
Emergency Department Example:

50,000 \times 35\% = 17,500 \\
17,500 \times 50 = 875,000
Dollar Impact of...
Emergency Department Co-payment collections

Based on: Estimated 35% with co-payment due.
Average co-payment of $50
Billing claim denials related to registration errors are preventable through increased training, systems edits and level of integration with real-time support systems.

Registration vs. Non-Registration Denials

- Registration Denials: 47%
- Non-Registration Denials: 53%

Source: RCS client database
Typical Denial Breakdown

Registration Denial Breakdown

- Non-Covered Charges: 27%
- No Auth/No Pre-Cert: 11%
- Patient Not Eligible: 17%
- Benefit Max Reached: 38%
- Wrong Payor/COB: 7%

Source: RCS client database
“Plan for Change”

- Systems & Equipment
  - Real-time system edits to guide accurate registrations
  - Verification systems integrated vs. non-integrated
  - Identification and trending of pre-bill / pre-claim edit issues
  - Other necessary equipment to support staff efforts such as telephone, fax & computer
## What is Possible?

<table>
<thead>
<tr>
<th>Function / Effort</th>
<th>Hospital</th>
<th>Target/Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Non-Urgent Patients Pre-verified</td>
<td>15%</td>
<td>92%</td>
</tr>
<tr>
<td>% of Non-Urgent Patients Pre-Registered</td>
<td>25%</td>
<td>92%</td>
</tr>
<tr>
<td>Insurance Co-Payments Collected Prior to Services</td>
<td>2%</td>
<td>61%</td>
</tr>
<tr>
<td>Insurance Co-Payments Collected at time of Service, specifically in the ED</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>% of Unbilled AR related to Registration Issues</td>
<td>10%</td>
<td>3%</td>
</tr>
<tr>
<td>% of Denied Claims Due to Registration Errors</td>
<td>50%</td>
<td>10%</td>
</tr>
<tr>
<td>Average Patient Registration Wait Time</td>
<td>13 Minutes</td>
<td>5 Minutes</td>
</tr>
</tbody>
</table>
Steps to success....

- Staff areas appropriately
- Adequately train all staff
- Schedule as many patients as possible
- Pre-register as many patients as possible
- Pre-verify as many patients as possible
- Audit registrations
- Collect, collect, collect!!
Benefits Realized…

- Increase accuracy of data capture
- Optimize patient through-put
- Increase cash flow
- Reduce claim denials
- Decrease associated bad debt
- Improve patient experience
Revenue Cycle
Four Points by Sheraton, Pittsburgh North, Warrendale, Pa
Friday, April 13, 2007

7:30am - 8:00am  
Registration & Continental Breakfast
Walk-ins Welcome

8:00am - 8:05am  
Welcome & Introduction
Sam Baker, President
Western Pennsylvania Chapter of HFMA

8:05am - 9:00am  
Keynote Speech: Healthcare
Jason Altmire, U.S. House of Representatives
4th District of Pennsylvania

9:00am - 9:15am  
Break

9:15am - 10:30am  
Revenue Cycle: Patient Access - “The Big Opportunity”
Dan Thiry, Principal, Revenue Cycle Solutions, LLC

10:30am - 11:45am  
Denial Management – Impact and Causes
Jim Tarasovitch, CFO, Bradford Regional Medical Center
Bill Schaude, Partner, ACS Healthcare Solutions

11:45am - 12:45pm  
LUNCH - “Working Lunch with Presentation”
Update on CDHPs
Loren Rothschild, United Healthcare

12:45pm - 1:00pm  
Break

1:00pm - 2:15pm  
Patient Access Workshop
Dan Thiry, Principal, Revenue Cycle Solutions, LLC
Colleen McMahon, Senior Consultant, Revenue Cycle Solutions, LLC

2:15pm - 3:30pm  
Denial Management Workshop
Jim Tarasovitch, CFO, Bradford Regional Medical Center
Bill Schaude, Partner, ACS Healthcare Solutions

3:30pm  
Adjournment