Revenue Cycle Payment Clarity
What It Is, Why It Matters, and How It Can Help Your Patients and Your Bottom Line
Executive Summary

Healthcare providers today are principally concerned with two things: first and foremost, providing quality care to patients; second, getting paid for that care. Unfortunately, while advances in medical science and technology are making it easier to help patients get well, a tidal wave of reform is making it harder to get paid.

Higher deductible plans and cost sharing mean that insured patients owe more. And as patient out-of-pocket expenses rise, so will the amount of bad debt carried by hospitals.

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Hospitals’ total cost of uncompensated care reached $46 billion in 2012, equal to about 6 percent of their expenses, according to the American Hospital Association. While much of this figure is generated by medically indigent or uninsured patients, unrealized co-pays or deductibles for insured patients also contribute. And although the Affordable Care Act (ACA) has helped reduce uncompensated care related to uninsured patients, it also has dramatically increased the number of Americans covered by high-deductible plans.

The Kaiser Family Foundation reports that 41 percent of Americans who get health coverage at work must pay at least $1,000 in deductibles before their insurance begins paying (up from 10 percent in 2006).

The increasing prevalence of high-deductible health plans, evolving payment models and regulatory changes are leaving a growing number of patients liable for larger portions of their bills, and providers unsure about reimbursement.
In this environment, healthcare providers need payment clarity – visibility into when and how much they will be paid, by whom, and the ability to better navigate the many obstacles to payment.

Today’s patients are savvy healthcare consumers, and demand transparency into what they will owe – up front. Studies show that when patients receive timely, accurate information in advance, they are more likely to pay. Confusion over insurance jargon (only 14 percent of insured adults correctly understand terms like deductibles, coinsurance, co-pays and out-of-pocket maximums\(^{iii}\)) and fears about overpriced care\(^{iv}\) contribute to patient unwillingness to pay.

To remain financially viable, providers must be able to furnish accurate cost estimates to patients prior to service, and be ready to collect more from them at the point of service. And they must be sensitive in their collection efforts, as patient satisfaction scores are not only used to inform federal payments for healthcare services, but patient collections are increasingly linked to overall satisfaction.

Payment clarity touches providers, payers, and patients alike across the entire financial continuum. This paper will illustrate the market influences driving the need for clarity throughout the payment process, and identify the opportunities where tools and processes can be deployed to address the issue. The good news is that payment clarity is achievable, both with existing solutions and a host of emerging tools.
A Perfect Storm of Reform

Patient Payment – More Covered, But Paying More

The overwhelming trend today—both for individuals with employer-sponsored insurance and those buying it through government exchanges—is toward high-deductible plans. A 2014 survey by the National Business Group on Health found that the number of employers offering workers a consumer-directed health plan (CDHP) as the only benefit option will rise by nearly 50 percent in 2015. More than half of respondents are implementing or expanding CDHPs.\(^v\)

Meanwhile, the Kaiser Family Foundation found that the share of workers covered by employer-based health plans who faced a deductible rose from 55 percent in 2006 to 80 percent in 2014.\(^vi\) At the end of 2014, The Commonwealth Fund reported that among adults with health insurance during a 12-month period, 21 percent spent 5 percent or more of their annual income on out-of-pocket costs, and 13 percent spent 10 percent or more.\(^vii\) Over the last decade, the average premium for family coverage has increased 80 percent.\(^viii\)

Regulatory Uncertainty – Delays Expected

Exactly how much of an impact ICD-10 will have on hospital revenue cycles in the wake of the October 1, 2015 deadline remains to be seen, but it could be substantial. The Work-group of Electronic Data Interchange (WEDI) believes that Accounts Receivable (A/R) days may increase by 20-40 percent after October 1st. It estimates that rejection and denial rates may increase by 100-200 percent during the same period.\(^ix\) The bottom line is that ICD-10 and other regulatory changes add complexity to an already challenging environment – further muddying the payment clarity waters.

Changing Reimbursement Models – Shift to Value

Although the majority of payers continue to use traditional fee-for-service models, value-based reimbursement (VBR) models are gaining momentum. More than 90 percent of payers and 81 percent of providers are deploying some mix of VBR combined with fee-for-service, according to a 2014 survey by ORC International (sponsored by McKesson Corporation).\(^x\) Participants in the study said they expect the proportion of fee-for-service payments to decrease significantly—from 56 percent today to 32 percent five years from now.
Cost Transparency & Understanding Reimbursement

Medical debt is a growing problem in the U.S., and is no longer limited to the uninsured. One in four individuals had difficulty paying medical bills in 2012, according the Kaiser Family Foundation. In the past, such debt was often due to a lack of insurance. Today, 70 percent of people reporting problems with medical debt are insured, and cost-sharing is cited as the leading contributor to the debt.\[xi\]

Millions of Americans are newly insured due to the ACA, and millions more have moved (or been moved by their employer) to high-deductible plans. As they navigate the system for the first time or try to make informed healthcare choices, they are often disillusioned by confusing, unclear and hidden costs. They want to know what they will owe.

Accurate estimations of patient financial liability and the ability to collect on that obligation at the point of service can help reduce bad debt – and increase patient engagement and satisfaction. But determining what a patient will be responsible for (within reason) and providing visibility into that cost remain a serious challenge for hospitals.

A report card prepared by Consumer Reports and nonprofit Health Care Incentives Improvement Institute gave 29 states a failing grade on price transparency. Seven states received a D, and only two states received an A. Massachusetts was one of those “A” states. In 2013, it became the first to require payers to provide their members with cost estimates for specific tests, procedures, and office visits within two working days. In October, it began requiring insurers to post online up-to-date prices for procedures by provider. Hopefully, other states will follow Massachusetts’ lead, but even its advanced program has flaws. For example, posted prices do not include facility fees, one of those “hidden” costs that can cause a patient’s final bill to be significantly higher than expected.\[xii\]

In addition to providing cost transparency for patients, providers require visibility into what they should (and will) be reimbursed by payers. To succeed on both fronts, they need a reliable way to validate a patient’s identity, financial capability and propensity to pay (beyond a credit score), benefit eligibility, and available coverage. This includes not only whether they are eligible, but what their deductibles are, whether authorizations are in place, and the estimated liability on how much they will owe. With this information at the beginning, providers are better able to address the patient payment clarity portion of the equation, which impacts the rest of the revenue cycle.
Opportunities for Payment Clarity Throughout the Revenue Cycle

To achieve true payment clarity, healthcare providers must implement technology solutions and processes that help automate and streamline everything from pre-service patient access functions, including pre-authorization, to claims management and processing, denial management and (ultimately) the identification and management of payer payment variances.

Patient Access/Pre-Service

Successful solutions and processes here at the critical front-line can help mitigate obstacles to payment further downstream in the revenue cycle.

Today’s pre-service solutions help simplify and accelerate front-office duties such as validating patient ID, verifying benefits and eligibility, identifying whether authorization is required and determining medical necessity. They enable patient access staff to accurately determine the patient’s financial responsibility, assess the patient’s propensity to pay and also check for charity options for patients who cannot pay. Most important to patients with high deductibles, they calculate pre-service bill estimates and create a recommended point-of-service deposit.

By identifying and correcting registration errors at the beginning of the revenue cycle, patient access automation solutions help ensure accurate data to enable providers to mitigate denials, decrease claim rejections and statement returns, and improve patient satisfaction when claims are processed accurately and quickly. Ultimately, they help improve cash flow, reduce accounts receivable (A/R) days, and decrease bad debt.
Claims Management
Smart claims management is the key to timely cash flow, yet the process for many providers remains painfully antiquated and time consuming. Traditional claims management is unnecessarily labor-intensive and complex – relying on schedule-based worklists to coordinate follow-up activities with payers. With a more targeted focus, users can positively influence their productivity and help speed receipt of payment.

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Claims management systems help take the guesswork out of claims processing and monitoring and reduce manual touch points that hinder productivity. Advanced automation solutions should include exception-based workflows that flag claims that need attention – allowing billers to focus on only the ‘problem’ claims.

Such systems also help lower denial rates by identifying coding errors and claim issues prior to submission – and by helping users ensure that claim edit information is up to date. Visibility into the claims system means staff can instantly check a claim’s status, be alerted if/when an issue develops, readily determine whether the issue stems from the payer or the provider, and be timely and targeted with claim follow-up.

Analytics
Patient access and claims management solutions generate a lot of data. But most healthcare organizations lack the ability to unlock the true value of all that information. When that data originates from disparate sources or is outdated, it’s nearly impossible to extract the insights needed to support strategic decisions.

**Most healthcare organizations lack the ability to unlock the true value of patient access and claims management data.**

Advanced analytics solutions can extract key data – about patient access, billing efficiencies, denials, reimbursement, payer relations, the impact of regulatory changes, charge processes and clinical services – to further illuminate payment. That data can also be compared to results from peer organizations to establish benchmarks and gauge performance. The ability to analyze financial performance and operational results across the entire revenue cycle without stretching IT department resources will help hospital leaders make informed, strategic business decisions more quickly.
Patient Portals & Online Account Management

Increasingly, providers are realizing the need to collect from patients at every point in the care continuum. Doing this, while maintaining (ideally, increasing) patient satisfaction can be a delicate balancing act.

With patients responsible for a growing portion of their bills, online account access and convenient payment options not only help reduce A/R days, increase cash flow and eliminate bad debt – but also help further patient engagement and boost satisfaction by increasing transparency.

One U.S. hospital system used an online patient portal along with a patient financial advocacy program to boost online patient payments by 40 percent.

Working in tandem with patient access solutions, online account management systems help providers gain clarity into what insurance expects the patient to pay, which not only helps provide cost transparency to patients, but enables collection at every encounter.

The benefits can be substantial and immediate. One U.S. hospital system used an online patient portal along with a patient financial advocacy program to boost online patient payments by 40 percent, realize a $1 million year-over-year increase in insurance self-payments, and dramatically reduce call center volume.
Planning for the Future

The pace of change across the industry doesn’t appear to be waning. With the looming transition to ICD-10, increased focus on pay-for-performance, more complex reimbursement models and evolving plans, providers will benefit from enhanced visibility into claims, denial workflow, and how these relate to appeals and payment variances.

These influences will also drive the evolution of revenue cycle solutions that promote payment clarity. For example, as revenue cycle solutions mature, they will include more embedded estimation capabilities. And as clinical information is used to confirm authorizations, healthcare providers will have everything needed to furnish timely and accurate estimates.

The capability to determine patient liability on the front-end, coupled with a clearer understanding of the payer payment can be used on the back-end of the revenue cycle to verify payment accuracy. As with current contract management systems, when a remittance is received the provider will match it not only with the submitted claim, but with the estimation of what should be paid based on the payer contract. This emerging capability, payment variance management, goes beyond simply indicating whether a claim or service line is denied, but whether the payment received is line with the contracted amount.

Taking claims status and claim follow-up visibility a step further, emerging claims management solutions will automate the management of appeals when a denial is received or payment variance is detected.
Summary

The combination of rising patient costs and declining reimbursements, exacerbated by sweeping healthcare reform is driving new fundamental changes throughout the healthcare industry. These changes, in many cases, are threatening the fiscal fitness of healthcare providers.

Payment clarity is rapidly moving from a “nice to have” to a necessity. Those provider organizations that master it will dramatically reduce their exposure and bad debt – while significantly enhancing patient satisfaction and loyalty. Those that don’t could face an uncertain future.

While there is little we can do about skyrocketing deductibles and consumer debt, we can implement the tools and processes that help provide payment clarity and accelerate revenue.

A growing number of healthcare organizations are currently focused on payment clarity in the pre-service area. This is important and, as mentioned earlier, sets the table for the rest of the revenue cycle. But hospitals need clarity throughout the payment process. With the ICD-10 deadline looming and as the shift to new reimbursement models begins in earnest, visibility into the who/when/how much of payment becomes a lynchpin to a hospital’s financial viability.

Comprehensive payment clarity begins with ready access to accurate, up-to-date information on every patient and every claim in the billing system. Once that data is consistently being used to lower denial rates, improve cash flow and give patients the cost information they need, hospital executives can (and should) turn their attention to more advanced payment clarity measures, which include streamlining the appeals process and better management of payment variances.

Health systems must be ready to financially clear, educate and manage the considerable influx of newly insured patients. Leveraging the process changes and tools to help improve the revenue cycle at pre-service, point-of-service and post-service, and creating a payment system that is optimal for both hospital staff and patients is essential to financial viability.
How RelayHealth Financial Can Help You Achieve Payment Clarity

RelayHealth Financial’s revenue cycle and analytics solutions give hospitals the tools they need to gain payment clarity. Collectively, they enable efficient management of the entire financial cycle, and help providers identify opportunities for and implement improvements, optimize operations, and deepen patient engagement and loyalty.

RelayHealth Financial solutions facilitate patient financial clearance before or at point of service, offer online patient account management and bill pay, and speed the claims and remittance management process. Advanced analytics help to identify and quantify opportunities for strategic action to improve financial performance.

The RelayHealth Financial platform processes 2.3 billion financial transactions annually and connects more than 1,900 payers, and 2,300-plus providers – providing deep transactional data analysis. Cost-effective SaaS deployment means easy implementation, lower overhead and reduced capital investment – so users can quickly realize the benefits of the solutions.

Patient Financial Visibility – RelayClearance™ Plus

RelayClearance™ Plus helps hospitals and health systems financially engage patients from registration through collections. The solution helps accelerate patient collections at all points of service and also assists in preventing denials. It helps calculate pre-service estimated bills to properly set patients’ financial expectations and presents users with a recommended point-of-service deposit that takes into account each patient’s financial circumstances—helping to streamline the collections process.

RelayClearance Plus helps identify errors at registration to provide accurate data for all downstream processes, helping to reduce denials, enhance financial performance and keep cash flow constant. It helps streamline point-of-service collections by leveraging co-pay and bill estimate information to direct staff towards what amount to collect. It determines if a pre-authorization is required and on file, monitors payers for pending pre-authorization decisions and updates the HIS/Practice Management system with payer results. It also alerts users to patients who cannot pay and should be evaluated for charity, Medicaid, or other financial assistance, and provides an online charity screening interview and enrollment form.

Online Account Management – RelayAccount™

RelayAccount™, RelayHealth’s online account management solution used by hospitals, physicians and patients, provides complete, instant visibility into who owes what, and for how long. This information allows hospitals and health systems to engage patients in financial discussions and collect one-time and recurring payments at every encounter – and also online via a patient portal. Patients, meanwhile, gain convenient 24x7 access to account information, and can pay via
multiple options. RelayAccount helps healthcare providers increase patient payment clarity by empowering them to:

- Consolidate billing information across multiple facilities;
- Increase collections by engaging patients at all points of service;
- Improve productivity and reduce calls through an online business office;
- Ensure up-to-date records and eliminate manual processes with payment posting;
- Capture multiple account payments for a single guarantor.

**Intelligent Claims Management – RelayAssurance™**

RelayAssurance™ Plus provides complete transparency into the lifecycle of claims. It helps manage all claims, including Medicare, Workers Comp and Property & Casualty, in a single web-based system. With connections to 1,900 health plans, comprehensive and current edits, and user-friendly workflow, it helps users efficiently manage the claims and remittance process to help keep cash flowing.

RelayAssurance provides actionable visibility into claims that require attention — at precisely the right time. Timeframes for payer responses and claim follow up are pushed to the user, empowering staff to focus on claims that need attention. This real-time transparency not only helps drive down administrative costs for providers, but also for payers, who routinely supply information multiple times throughout the claim cycle.

**Analytics – RelayAnalytics™ Acuity**

RelayAnalytics™ Acuity is designed to help hospitals capitalize on the data they have to improve their business. Acuity leverages a large volume of eligibility, registration, claims and remittance data to provide holistic revenue cycle insight that can help hospitals make strategic decisions to drive business process improvement and expedite revenue.

It enables analysis of patient access, billing efficiencies, denials, reimbursements, payer relations, ICD-10 impact, charge processes and clinical services. Dozens of pre-packaged reports align specifically to business processes impacting the revenue cycle and can be easily customized.

**RelayAnalytics™ Pulse**

RelayAnalytics™ Pulse delivers fresh, equitable data from hospitals across the country so providers can compare performance to peers and establish benchmarks. Easily viewed, accessed and analyzed, this data supports strategic decision making to help accelerate revenue.

RelayAnalytics Pulse provides:

- Daily data updates for immediate insight
- Comparative analytics from hundreds of hospitals
- Automated collection and consistent calculation of peer KPIs
- Strategic financial trend dashboards
- KPIs to quantify financial opportunities
Endnotes


