Connecting the dots: Back-end business operation improvements begin with front-end patient access

Patient Access has become the first line of defense to every health system's ability to sustain positive public favor and a healthy bottom line. Health reform and seismic shifts in payor mix and patient health benefits may mean that your patient access staff, process and technology is in need of improvement.

As insurance coverage has changed and patients have assumed more of the payment responsibility, your financial clearance for service line eligibility verification, patient liability estimation, upfront medical necessity checking and prior authorization have dramatically intensified. Case in point, there has been a six-fold increase in patient liability for deductibles and co-payments compared to just a few years ago.

The increasing cost of failing to connect the dots

Before reform, it was commonly acknowledged that two-thirds of the information collected at the time of registration will be used on the final bill. Inaccurate and incomplete information gathering on the front-end in patient access means someone on the back-end will be committing lots of extra work hours to fix issues to avoid denials and payment delays.

If your denials exceed more than 2 percent of hospital cases, it's time to take a look at the root causes. As you can see from the diagram that follows, patient access contributes the widest spectrum of denials.

It's a good bet that patient access can provide one of your greatest opportunities for rapid financial improvement.

Connecting the Dots for Improved Performance

Denials related to Patient Access

- Authorization
- Benefit Plan Coverage
- Benefit Maximums Exceeded
- Coordination of Benefits
- Credentialing
- Eligibility
- Experimental Procedure
- Pre-Existing Condition
- Medical Necessity

Denials related to HIM, Charge Capture, Coding

- Documentation
- Coding

Error rework from **Patient Access**

- Authorization
- Benefit Plan Coverage
- Experimental Procedure
- Medical Necessity

Denials related to Billing and Collection

- Bundling
- Demographic Mismatch
- Timely Filing

Error rework from **Patient Access**

- Authorization
- Coordination of Benefits
- Pre-Existing Condition

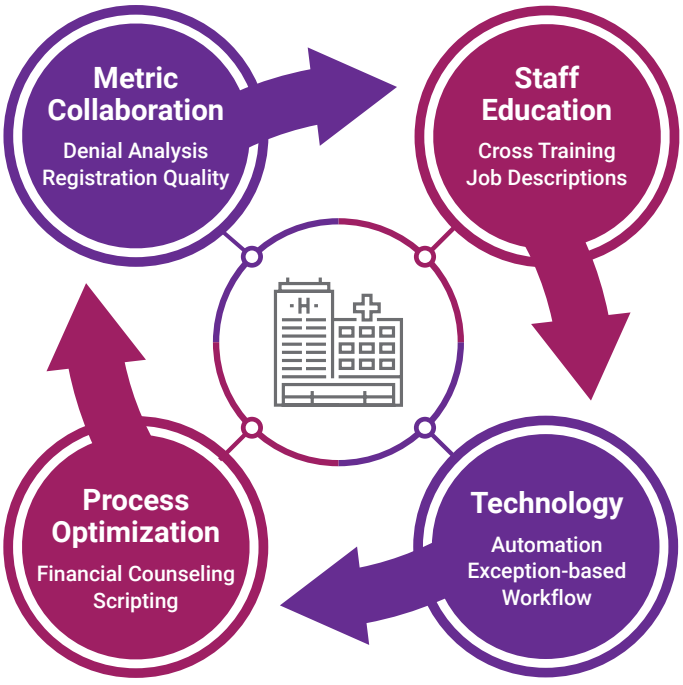
What are the performance gaps?

Your bottom line depends on the capabilities of your front office staff to perform all the essential financial clearance steps, including securing point-of-service collections from patients. Has your health system made the appropriate investments in people, process and technology to position your patient access team for success? Have you ensured that your patient access and billing staff collaborate to avoid silos that adversely impact your financial performance?

If you are cost constrained to hire more people or elevate salaries, you are not alone. Given these constraints, let's explore strategies to help your staff be more effective.

A pragmatic way to bridge the gap: Four key strategies

Here are four pragmatic and high ROI strategies to connect the front-end of your revenue cycle process to the back-end office to dramatically impact efficiency, reduce denials and improve reimbursement:



1 Collaboration Meetings on Metrics

Establish a weekly or monthly meeting between your patient access and billing office to focus on denials and registration quality. Attendees should include the business office director responsible for denials and follow-up, billing manager, denials analyst and revenue cycle managers for patient access and coding. This provides a strong learning opportunity to share metrics and create transparency. Remember to keep the meeting focus on the data, to remove the potential for defensiveness.

- Agenda topics should cover denial categories for deeper dive analysis including billing denials, non-covered services, coverage terminated and denials based on misidentification of primary vs. secondary insurance.
- This meeting is not a one-off process, it serves as your leadership checkpoint for an iterative, ongoing analysis conducted by the larger group of revenue cycle staff, preferably through daily huddles. Summarize action plans and takeaways for specific types of denials and ensure leadership communication back to the frontline staff so they hear feedback and understand the issues to avoid.

2 Staff Education and Skillsets

Does your health system have new employees shadow a more senior person? If so, have you validated that the tenured employee adheres to your best practices for quality assurance? Here's how to foster performance.

- **Cross-Seed Training.** As a practical workaround, create a revenue cycle trainer position filled by a seasoned person from your billing office. Select an individual that has an aptitude and willingness to learn technology that is capable of spearheading and managing through daily patient access challenges. You can reduce turnover rates by presenting a visible role model for a career path.
- **Develop Roles.** Positioning a financial counselor role as a next step career progression also works well for retention rates and continual learning. Your financial counselors will develop understanding of both the front-end and the back-end billing function of your health system.

- **Expand Training.** Best practice training programs can evolve the entry level patient access employee to someone who has more knowledge of payor contracts and how each payor works. Programs should include the following scope: data capture procedures, insurance verification processes, registration system training and processes, best practice collection techniques, working with financial counseling forms and documents.

  Activate a calendar mechanism for continuing education of your existing staff as the insurance market continues to evolve. Engaging your billing and collections staff in the training curriculum also works well to further expand continuing education of your patient access employees.
- **Set Expectations**. Conduct a thorough review of existing job descriptions and assess how the distribution of duties are flowing within the patient access department. Job descriptions help organizations set the right expectations for new hires and employee performance management. With that analysis, you can create an onboarding process that exposes new employees to expectations of their role. This should include translating the roles into training modules on the right procedures for specific services, e.g., how to verify benefits or even how to read insurance cards. Establishing a constant feedback loop for new employees, creates a platform for continual improvement.

3 Process Optimization

Are you finding your collections are too low even with front-end technology in place? When patients are getting admitted prior to checking liability or ability to pay, it's often because the emergency room clinical staff are not comfortable with tackling payment conversations, or the patient access staff cannot explain benefits or are timid about asking for money. The same thing holds true for hiccups in scheduling processes. Even with scheduling technology, if there isn't enough time allotted to verify insurance, your health system cannot get authorization in time and the financial counselor doesn't have time to explain that the patient owes out-of-pocket expenses.

To create a foundation for optimal point-of-service collection you need to redesign and improve processes. One of the easiest ways to begin is to provide staff education on best practice financial conversations that incorporate scripts of what to say and role playing of scenarios. It's also important to ensure that all staff are trained and accomplished users of technology, so they have everything needed to support a positive upfront patient collection experience.

4 Technology to simplify quality management and improve reimbursement

Patient access software that can automate some of the most labor intensive processes can improve efficiency, prevent denials, as well as indirectly educate patient access employees on how payors work. These types of systems feature exception-based rules to flag when key upfront information gathering is insufficient. Investment in capabilities that create more accurate front-end edits can help you prevent errors from getting passed along to the billing scrubber, or the billing office thereby expending resources to correct them on the back-end.

THE BOTTOM LINE

Reconfiguring the staffing compensation models and skillsets of patient access employees is inevitable, but revamping them can seem formidable from a budget perspective. Cost and competitive pressures, however, demand that your health system look at pragmatic proven blueprints to enhance the performance and remove the isolation of the front-end of the revenue cycle. In this environment of shrinking margins and greater patient responsibility, there's no better time to position your health system for financial performance by investing in patient access. You can deploy game-changing collaborative metric meetings, staff development, process optimization and registration technology for low cost, high return results.

If you are looking to simplify your financial clearance and improve cash flow, call upon nThrive. We deliver consulting services, interim staffing, technology and financial clearance center outsourcing to help you achieve your reimbursement goals from Patient-to-Payment℠.

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