5 Ways Volumes Break Things – And How To Fight Back

A Strategic Response to Increasing Patient Account Volume

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Introduction

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A Strategic Response to Increasing Patient Account Volume

Your patients deserve the care afforded by new efficiencies and economies of scale – opportunities often created by new alliances, mergers, and acquisitions. But greater centralization and new regulations throw a greater volume of information at semi-automated and manual systems, volumes that can tend to break those processes.

We call these new forces Volume Busters. Here are the 5 major ways they’ll find their way to healthcare providers, and how you can manage them strategically:
#1

Mergers & Acquisitions

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#1

Mergers & Acquisitions

Healthcare reform and a shift toward value-based payment have created a wave of M&A activity. In 2011, the number of independent community hospitals stood at 1,966 according to the American Hospital Association's 2013 Annual Survey (To Remain Independent or Not, HFMA March 2013), down from 2,700 in 2010. This trend has not subsided in the past few years as independent hospitals and physician practices announce plans to affiliate or consolidate with other providers.

These initiatives can certainly bring about new efficiencies and synergies between hospitals and physician offices. But they can also bring disparate business office infrastructures together, sometimes presenting technical hurdles and information silos. When multiple operations merge into one entity, a much higher volume of information must be leveraged across that single system. The new entity's policies and technology need to be able to handle those volume demands.

To address the issue, the business office needs an enterprise-wide response to accounts receivable management. A common AR system will enforce the steering committee’s business rules, apply automation to formerly manual processes, and drive exception-based workflow to each account representative’s desktop. Without those tools, exposure to higher days revenue outstanding becomes a risk, along with increased bad debt, and declining cash from patient payments.

If a merger or acquisition is on the horizon, start thinking now about how your team and the technology you use will handle the volume.
#2

New Physician Alliances
Hospitals embracing the principles of clinical and financial integration stand to perform better than those that have not (Financing Your Strategic Plan, HFMA January 2013). That opportunity has created a trend toward new alliances with doctors that shows no sign of slowing. Many factors influence an alliance between the hospital and physicians, including alignment to mission, market factors, financial status, and the potential revenue and cost saving benefits of the alignment. But no matter the result of this scorecard, the end game dramatically increases AR management for the business office.

Physicians bring with them a characteristically high volume of accounts and patient liabilities that add to the burden and risk of the hospital business office. It doesn’t matter if they return as W-2 employees or under increasingly popular professional service agreements (PSAs) – in every case, the AR responsibility is shouldered by the hospital billing office (Leveraging Non-Employment to Achieve Hospital-Physician Alignment, HFMA April 2013).

Have a plan in place to properly onboard physician accounts, and a strategy to work them automatically and consistently. The high-volume, low-balance nature of those claims and patient liabilities depends on it.
#3

Aging Patient Populations, and High Deductible Health Plans (HDHPs)
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According to the AARP, 8,000 patients age into Medicare every day – a significant trend upward. The same study also indicates that 22% of those patients have no retirement savings, while 14% have no personal savings whatsoever. The next generation looks even worse: Of those 46 to 64 years of age, 26% have no personal savings. The average retiree spends $4,600/year on premiums, co-pays, deductibles and non-covered services. It’s estimated they’ll need between $200,000 and $500,000 over the life of their retirement for medical expenses. That should indicate new Medicare beneficiaries aren’t likely to display the same repayment behavior as today’s.

To make matters worse, more employers are using high deductible health plans (HDHPs) to provide insurance coverage every day. Their use is up 46% since 2010, representing nearly 20% of overall commercial insurance enrollment (AHA Chartbook 2012). Those plans are here to stay, and that means more patients will be covering more of their own healthcare costs, a burden for which many are unprepared. In turn, that means increasing risk and volume across your patient liability portfolio at a time when margins continue to tighten.

Revenue cycle leaders need a perspective that views patient liability volume as a financial portfolio – an approach that requires a strategic response. Account segmentation and scoring, automated workflow, contemporary contact management with patient preference understanding, and self-service options to keep the business office open 24/7 are tools that can help.
#4
The Patient Protection and Affordable Care Act (PPACA)
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The PPACA will undoubtedly bring new insurance options to more than 32 million Americans, but it certainly doesn’t ensure their claims will be paid more efficiently or on time. 32 million newly insured patients will mean a mind-bending quantity of new insurance claims. This increased patient volume – which will require more insurance claim billing and follow up – may also be managed at a reduced reimbursement rate. Robust denial management and expedited workflows are more important now than ever before.

As insurance exchanges provide Americans new insurance options, many households may still face significant financial burden. Reduced on sliding scale based on income, the PPACA allows for annual out of pocket co-payments of up to nearly $6,000 annually ($5,950) per individual, and nearly $12,000 annually ($11,900) per family (Kaiser Family Foundation). This is, of course, in addition to premium payments. While insurance exchanges promise a great deal of relief from the catastrophic situations that bankrupt so many Americans, they may not provide much relief for hospitals in terms of the dollars that can be realistically expected from each account.

It’s likely we’d all benefit by reviewing our current policies and technology to ensure we have a robust self-pay, insurance follow up, and denials management response.
#5

501(r) Regulation
501(r) Regulation

The U.S. Treasury and IRS are still considering comments made last September that will reshape how financial assistance and self-pay collections are managed by charitable hospitals. We won’t cover all their intricacies here, but the proposals made can still be used as a basic roadmap for 501(r) planning.

Specifically, 501(r) states that hospitals will be required to make reasonable efforts to determine whether a patient is eligible for a financial assistance program (FAP) before engaging in extraordinary collection activities. The patient has to be notified, offered resources to fulfill their eligibility, and receive a determination of that eligibility. In addition, that patient must be afforded a 120-day “notification” period that begins with the first billing date, along with a second 120-day “application” period when they can submit. And if a hospital refers or sells an individual debt to a third party during that application period, that third party is bound by the same rules.

Sounds complicated, right? More importantly, doesn’t it sound like a ton of documentation?

Under 501(r) regulation, all of these activities have to be consistently applied and documented – processes best not left to human oversight and error. A strategic platform must be deployed to drive the workflow, manage notifications and application periods, capture important documentation, and manage and deliver determinations. This new volume and workload brings with it the kind of administrative burden that existing talent and technology cannot manage.

Charitable hospitals must develop FAP workflows and specific controls to ensure appropriate notification before collection action is initiated, accounts are placed with third parties, and patients are reported to credit agencies.
About Ontario Systems

5 of the 10 best healthcare organizations in the country*run their receivables operations on Artiva Healthcare from Ontario Systems—a comprehensive solution delivering a fully-fused contact management system, professional services, and business expertise. Organizations using our products are 200% more profitable in their revenue recovery efforts on average, leveraging our technology to ensure compliance and sensitivity to patient needs at every step of the process.

Our 30+ years of experience enabling innovation, strategy, legal compliance, and efficiency have made Ontario Systems the receivables management technology provider of choice for more than 55,000 customer service representatives in more than 500 locations across the country. We uncover revenue opportunities to help our customers grow and prosper in complex industries.

An ideal platform for virtually any patient-focused company, Artiva Healthcare customers include:

- Hospitals
- IDNs, ACOs, and PHOs
- CBos
- BPOs and EBOs

Is your health system, team, or operation planning to deal with any of these issues? Or maybe you’re already in the thick of a new initiative? For more information about the topic in this ebook, or Ontario Systems’s Artiva Healthcare solution, please contact Steve Scibetta at: Steve.Scibetta@ontariosystems.com.

*U.S. News & World Report – Best Hospitals 2012-2013

About the Author
Steve Scibetta is a 20+-year healthcare technology veteran, having served roles in software development, product management, customer service, and business planning. Strategy, development, and competitive analysis are Steve’s bread and butter at Ontario Systems, where he brings channel partnership and strategic product management disciplines together to help healthcare clients achieve their most ambitious growth plans.