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CFO REALITY CHECK

Streamlining verification of benefits and medical eligibility: How CFOs can lead

The financial benefits of administrative simplicity: provider and payer CFOs discuss

Across the entire health care continuum, a lack of visibility to benefit data is a significant challenge for both payers and providers, and as a result, it's costing members a bundle.

According to a 2017 study by Change Healthcare, denials cost providers roughly $8 billion annually, with an average of $118 per claim.* In addition to the direct costs, both providers and payers devote costly resources to resolving claim denials.

Technology is making it easier for payers and providers to check medical eligibility and verify benefits at the time of care, but the financial cost of implementation — coupled with changing revenue models — is holding back innovation.

As two CFOs from opposite sides of the payment equation — a former hospital system CFO and a health care actuarial consultant — we believe payers and providers can attain their shared goal of lowering the cost of care while improving coordination of benefits.

Optum is becoming a more visible strategic partner in this process, helping improve benefit eligibility verification by improving documentation in coding and setting up the blocking and tackling payers need to lower operational costs.

Collaborative strategies have long proven to help providers and payers reduce bad debt, create training efficiencies and use fewer staffing resources. Here's how financial leaders can achieve revenue goals while improving cooperation throughout the industry.

Benefits of collaboration

There is a great deal of friction for patients, providers and payers when it comes to up-front insurance verification. With inaccurate or incomplete data, there is significant downstream impact on revenue for both sides of the process.

For example, consider a patient who has a procedure that they thought was pre-authorized and covered by insurance. After a year of wrangling between the payer and the provider, the patient receives a surprise bill. Both parts of the process have now caused pain for the patient, as well as friction and carrying costs for both the payer and provider.

There is also intense pressure on the provider side to improve margins, just like on the payer side. Each side has complementary goals and largely wants the same thing: a more efficient process that ensures positive patient experiences and clinical outcomes.

* Change Healthcare Healthy Hospital Revenue Cycle Index,' Change Healthcare, 2017 https://www.changehealthcare.com/blog/wp-content/uploads/Change-Healthcare-Healthy-Hospital-Denials-Index.pdf.

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Today, it may seem as if providers end up shouldering much of the burden for administrative costs related to collaboration. The reality is providers need to deal with multiple payers and TPAs, while payers need to work with a multitude of providers and various government entities.

Several technology systems can help ease eligibility verification between the provider, payer member in order to make sure that a claim gets paid. But doing it at the site of service remains a challenge, with downstream financial impacts to both payers and providers.

For example, revenue cycle management (RCM) technology now allows for estimation in real time, at the site of service. Back-end data and analytics systems can ensure that front-end systems are delivering accurate information.

Knowing all of the benefits allows providers to engage with patient options on the spot, informed by eligibility and verification, that improves up-front collections and reduces receivables.

Practicing collaboration

From the provider perspective, collaboration yields as much data as possible up front, in order to prevent problems downstream. Since much of the coordination now is manual, with staff picking up the phone, sending an email or exchanging faxes to resolve a single payment issue, collaboration is now a rather inefficient process.

Consider how banks are using technology to make payment processes more efficient. In the health care industry, pharmacies are leading the way — they have direct access to patient benefit levels and out-of-pocket costs. Both providers and payers can emulate these advances by understanding the value and downside risks for each party.

For example, when providers are required to submit specific documentation to payers in advance of a major procedure like surgery, time is of the essence to ensure a positive outcome. Often, surgeries or pre-procedure lab work will have to be put off while providers re-submit documentation for approval.

While providers are focused on near-term financial and patient care priorities, payers tend to take a long-term view, given the different revenue cycles between the two sides. Understanding these priorities up front and delivering information with as little friction as possible is essential for collaboration.

Payers often have access to information that the providers don't have, including pharmacy benefit data, but they don't necessarily know what's happening outside of their provider group or healthcare system.

For example, if a patient has out-of-network benefits that are not visible to the provider, or carries secondary insurance, providers are unable to provide payment estimates or confirm benefits.

With providers clearly communicating benefits and eligibility to the patient based on payers sharing the information on a real-time basis, both can optimize the payment workflow on the front end.

Data-driven collaboration

We recognize within our industry that information isn't perfect. In fact, relative to other industries, health care data is quite "dirty." With employers and members changing health plans frequently, benefit and eligibility data quickly get outdated.

Even when members switch insurance plans, they still stay with the same doctor in most cases. But by the same token, providers must get better information from payers to help us define the parameters of what needs to be billed and which services are being billed before invoicing the patient.

Payers each have widely different rules that make it difficult for providers to find a "silver bullet" that solves this pain point globally, all the while incurring more costs for manual intervention on each case. Streamlining and automating the process with accurate, real-time data and analytics — meeting providers at their own levels of technology sophistication — is a key collaborative strategy that will tamp down administrative costs for both parties.

It's not a one-way proposition, either. Both providers and payers are risk-bearing entities, and unacceptable risks can spin costs out of control. Giving providers the ability to validate medical eligibility and benefits at time of service through more sophisticated and automated means will go a long way toward administrative simplicity.

Achieving collaboration

The industry is already seeing movement toward greater collaboration, with different payment models available through several Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) initiatives.

Payers are now working more closely with providers to help them qualify for some of the advance payment models included in MACRA, which are in turn helping providers save money by simplifying the process.

Consolidation is also driving collaboration. One of the unexpected benefits of increased consolidation in both the payer and provider markets is greater economies of scale. Accountable care organizations (ACOs) are a perfect example of consolidation efficiency.

Through the Medicare Shared Savings Program (MSSP), ACOs can accrue financial bonuses tied to quality metrics. This drive toward coordinated care has already reduced care costs and improved health outcomes for ACO members while driving provider savings.

Consulting strategists and third-party vendors are now managing many data exchanges between providers and payers, using EHR systems as a starting point for collaboration. These contracted relationships help reduce internal resource dedication to benefit and verification data sharing.

For example, Optum360 allows hospitals to outsource their billing functions, a huge need for rural hospital and provider systems in particular. It's much easier to find qualified medical billing professionals in big cities versus smaller markets. Providers can eliminate the costs of recruiting and hiring these positions through outsourcing.

Optum also has an executive health resource department for providers, a type of second-level review process for case management. This helps both providers and payers get authorization quickly based on review by third-party physicians. As collaboration continues to become a greater priority, we see more outcome-based care models and third-party services gaining traction within the industry.

The future of collaboration

As health care transforms from a fee-for-service to a value-based care model, we see payers and providers collaborating more frequently because they now each have more invested in each-other's ability to perform.

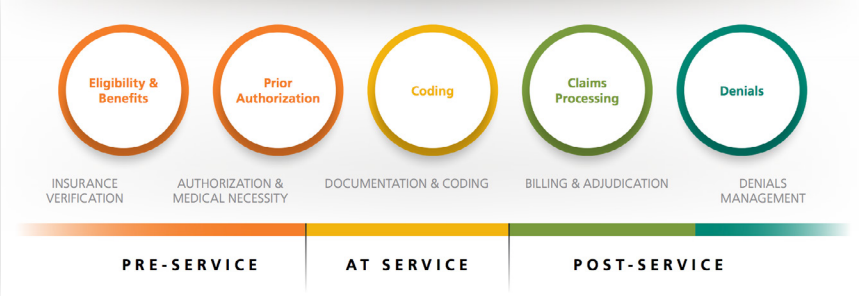
Consider the Centers for Medicare and Medicaid Services' Merit-Based Incentive Payment System (MIPS) program. A consolidation of four pay-for-performance programs, MIPS provides for enhanced-value reimbursement and quality measurement as part of the Medicare and CHIPs Reauthorization Act (MACRA).

This drive toward value-based reimbursement through initiatives like MIPS and MACRA has created financial incentives based on care quality and outcomes. However, in many cases, providers don't have health IT tools and practical experience to aid in the transition. Payers can help by prioritizing advanced analytics, data exchange, population health management and care coordination, while sharing their lessons learned from the Medicare Advantage Stars program.

The CFOs most important responsibility is to lower operational costs, and part of doing that is improving data exchange at every stage of the health care continuum. As a result, both payers and providers will improve opportunities to boost revenue while making the process simpler for patients.

Financial leaders can and should seize change-management responsibilities that help prioritize benefit and insurance verification on the front end. If both parties get better at documentation and coding, everything flows through information systems more easily.

There are many health care CFOs on the provider side that look at payers as adversaries, and vice-versa. In order to create the efficiencies necessary for cost savings and reduced friction, we believe that payers and providers – both risk-bearing entities – need to start acting like partners instead of competitors.



A lack of access to complete and current data that supports medical eligibility and verification of benefits is one of five key pain points highlighted in the Optum Payment Nexus infographic. Click here to explore the pain points and read about collaborative solutions for addressing each.

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