CELERACARE Technologies

THE LEADING-EDGE FOR HEALTHCARE SOLUTIONS

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THE GREAT HEALTHCARE SWINDLE

A familiar adage goes, "if it sounds too good to be true, it probably is." Unfortunately, healthcare reform plans in this country aren't sounding too good and healthcare itself most certainly has not remained true to us.

How often have we experienced instances where health insurance premiums have risen with little to no explanation at all? How can they do this? The simple answer is, because they can. Presently, health insurance payers are able to raise premiums under the guise of "to enhance coverage" but the real question is exactly how "enhanced" is the coverage when hospital bills keep showing up long after services have been provided?

It is widely held that the concept of health insurance was first proposed in 1694 by a Parisian obstetrician named Hugh Chamberlen.

Chamberlen advocated insurance as a means of safeguarding against unforeseen occurrence. By the late 19th century, in the United States, "accident insurance" had become more widespread for what is now understood to be disability coverage. Such coverage was primarily made available by the Franklin Health Assurance Company of Massachusetts. FHACOM originally offered insurance against injuries arising from railroad and steamboat accidents. Realizing profitability, more companies started following the model. The industry was consolidated in the late 1860s and sickness coverage became available by 1890. Before the inception of medical insurance, fee-for-service was the business model.

In order to support insurance coverage and downplay the fee for service model, hospitals adopted "stop loss" coverage plans as a means of acceptable losses for coverage amounts. When health centers began putting their faith in insurance coverage plans to provide reimbursement for services and began requiring payments from patients less and less, eventually asking patients for payment, the "ask proposition," dwindled and the swindle was on.

PATIENT FINANCIAL OBLIGATION?

Say it ain't so, Joe. The notion that patients are obligated to arrange payment for services provided to them is utter lunacy.

For Healthcare in the United States, such a notion would send shivers down the spine of any and all familiar with the "walk in, get treated, walk out, maybe get a bill in the mail days/weeks later, maybe pay the bill" procedure. Wash, rinse and repeat.

Truth be told, healthcare is the only industry where a service is provided and there is no uniformly defined method to ensure the service gets reimbursed (unlike the insurance industry where a payer may provide no service at all, despite continuous premium payments from members).

What if there was a solution to enable medical centers to provide service **AND** get paid?

INTRODUCING

REVENUEXCELERATOR™

INSIDE THIS ISSUE:

SPECIAL POINTS OF INTEREST:

- A HEALTHCARE CENTER DIVIDED AGAINST ITSELF CANNOT STAND
- REINVENTING THE WHEEL OF THE REVENUE CYCLE
- IS PATIENT FINANCIAL OBLIGATION FOR CARE FOR REAL?
- CLEARING AWAY THE CLEARINGHOUSES

THE COST SHIFTING DEBACLE

A gap has increasingly arisen between the cost of serving a Medicare or Medicaid patient versus the reimbursement received by a provider from the government for the service provided. Government prerogative opts not to shoulder some of the costs of serving people ineligible for government programs but who still cannot pay their bills. The government maintains that the "prudent purchaser" arrangement, which assumes a payer should not pay any costs generated by any other payers' patients, is effective enough to conduct "fair practice," thus birthing the issue over who pays the difference of the cost of doing business that is not directly allocated to a particular patient. With concern for provider reimbursement ever looming, many medical centers shift unreimbursed costs of servicing government plans to private sector payers. Such a shift leads to hospitals charging some patients (i.e. those who self pay or those privately insured through employer or commercial plans) more for the same service than others (i.e. those with Medicaid and/or Medicare coverage). To put it simply, the cost shifting debacle requires that the demand for hospital services by government program beneficiaries be met with increased hospital revenues or hospitals be forced to choose between reducing quality of care and shifting costs. In order to increase medical center revenues some strategizing must take place: a) increase fees for service and b) take on higher patient load. Summed up, in this country the so called "right" to healthcare has been written off as bad debt.

CHARITY CARE—IS PATIENT CARE PRIORITY ONE?

Also known as uncompensated care, charity care provides free healthcare to the uninsured whose income is, in some states, up to 200% of the federally designated poverty line. Within the continental US, the poverty line for a household with 1 person is an income of $10,830 or less. Add $3,740 for each additional person (source: *Federal Register*, vol.74, no.14, Jan.23,2009, pp.4199-4201). As hospital revenues fall, more and more medical facilities have taken under consideration forsaking (or at least reducing/limiting) Charity Care. It is federally mandated that emergency care be provided to any and all in need. However, ED registrations typically make up much less than one third, on average, of all visits annually. Which poses the concern as to whether or not patient care is, or should be, the top priority of any medical facility. To clarify, caring for emergency patients is a requirement regardless of income level and reimbursement capability, but if and/or when charity care is not available for eligible patients for treatment other than emergency care, priorities must be re-evaluated. Charity Care funds are often allocated and administered inefficiently. Thus it must be concluded that if there was a solution to aid in effective and efficient allocation and administration of charity care funds by increasing patient awareness of financial responsibility then patient care could remain priority one.

Contrary to accepted belief, patient care involves more than just clinical treatment

PATIENT FINANCIAL COUNSELING AND ADVOCACY

In today's economic environment, patients are more and more shopping for care based upon coverage. For hospitals, addressing this issue requires offering a proactive approach to determining patient financial coverage earlier in the revenue cycle at point of service (POS) instead of spending valuable time trying to determine and recover payment by post-billing services rendered. Establishing a means of providing financial counseling and advocacy aids in providing a blueprint for a customized plan of coverage. The patient's uneasiness toward pursuing care based solely on coverage then diminishes with the knowledge that their center for care is also their partner for financial care. To what end? Ineligible claims denials go down, A/R days decrease, revenues rise, as well as both patient visits and satisfaction increase.

Through all of this, the hospital is able to move into a more competitive position based upon determination of patient financial obligation for care at POS, thus providing the patient with peace of mind for both care and financial coverage and, ultimately, aiding patients along the path to wellness.

COST CONTAINMENT

Reducing Unnecessary Costs: Electronic Data Interchange technology allows for data transfer between trading partners. For many years, hospitals and insurance carriers alike have benefited through the usage of EDI to reduce operating costs.

Typically, hospitals looking to increase efficiencies have sought out BIG vendors offering an EDI solution in order to make use of that EDI availability. Such vendors are of course eager to offer their services, provided the hospital not only pay a one-time fee for utilizing their software in addition to standard ongoing support costs, but also pay a seemingly small per-transaction fee. The average transaction fee costs approximately $.20 per transaction. Most hospitals prefer to conduct multiple insurance and benefits checks (typically between 3-5 times per claim) prior to claim submission in order to ensure accuracy. That seemingly small $.20 transaction amount then adds up quickly. This all equals up to hundreds of thousands of dollars each year.

Many hospitals believe it is unfair for a hospital to be charged a per-transaction fee for information that should be essentially free (and rightly so) but keep paying the fees because BIG vendors tell them that it is the only way to get the data they so desire to operate successfully. The **REVENUEXCELERATOR™** solution eliminates transaction fees by utilizing a state of the art methodology. Electronic transmission + POS payment collection = postage cost reduction. A result from eliminating electronic transaction fees and increasing POS payments is that postage costs get reduced from rebilling less ineligible claims, as well as less staff time spent verifying patient benefits. This solution is in essence the tool which allows the medical center to strive less at working to pay for EDI and enables EDI to work for the medical center.

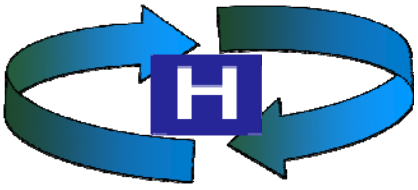
REVENUE OPTIMIZATION

The collection of patient payment has traditionally been a daunting task, to say the least. Most registration processes presently consist of either relying on the patient to know their correct co-payment and/or deductible amounts or collecting nothing up front, thereby requiring staff to track down the correct information by sending out correspondence or phoning in order to ensure the hospital gets paid its dues. As a result, an unnecessarily large amount gets written off to bad debt, with co-payments becoming devalued from the time and energy taken to collect them. Certainly sending out an invoice and waiting for payment (barring any discrepancies) cannot be the most efficient way to collect monies that have such a profound impact on the hospital bottom line. When that seemingly low amount is not collected, the costs involved in the struggle have a high impact. The answer is to provide more efficient methods to swiftly and accurately collect payment amounts right at the point of service (POS) through the application of electronic data interchange (EDI). With EDI, the information that previously took days or even weeks to obtain is gathered in just seconds! A solution should deliver the right tools necessary to not only collect co-payments in real time at POS, but also to expend less time, money and energy doing so.

Bad debt write-off amounts decrease given the ability to increase collection of co-payment and deductibles at point of service.

WORKFLOW ENHANCEMENT

For most hospitals, some of the biggest challenges faced during the patient registration process lie in the extensive effort and costs involved manually registering patients. Add to that, the seemingly endless amount of hours spent by staff verifying insurance benefits and the result is that payment is often not received until more than 45 days after services have been rendered. Why spend valuable time phoning, faxing, and wading through insurance red tape online when there is capability to electronically verify patient insurance information and confidentially identify both co-payment and deductible amounts during the initial registration process in less than 60 seconds?! The time taken by staff performing tedious manual processes could be better spent within the claims recovery process expediting payments for previously denied claims. The **REVENUEXCELERATOR™** solution securely transmits patient demographic and insurance information throughout each and every applicable department, thereby allowing staff to conduct their required tasks within minutes, as opposed to hours. Reducing errors, providing staff with a standardized set of information, and giving each employee the opportunity to re-run eligibility checks at no additional cost allows the hospital to minimize the time spent from registration to claims submittal.



...Providing Leading-Edge Health-Care Solutions

REVENUEXCELERATOR™

Bridging Communication Gaps In HealthCare

CELERACARE Technologies

44 Technology Way
Nashua, NH 03060

Phone: 603-546-7411
E-mail: info@celeracare.com

PATIENT CREDIT CHECKS

New car smell...ahh. We know it, love it, hate having to go through the motions to buy a car that has it. Car salesmen may be crafty, but they are no fools. They make sure to determine whether or not the potential buyer can afford the payment terms before the driver accelerates on down the road. How? They do so by checking the potential buyer's credit.

Cars, on the one hand, play a very minute role in a person's life. Hospitals, on the other hand, are where lives begin, get treated throughout, and get transitioned to their end. Why would a hospital or medical center not want to ensure means for a patient to pay their fee for service by checking credit and aiding in establishing a payment plan for the treated? Let's face it, if any and all of us want to keep the power on and all running smoothly at a med center then somebody's got to pay the bills, right?

Equifax, Experian and Transunion are the credit agencies holding all of our marionette strings. They exist to report on credit. Most businesses do not operate solely on cash in hand (or cash in briefcase as the case may be). Most businesses accept credit. Successful businesses do both as is necessary without letting the customer (and yes, patients are customers) walk away without providing reimbursement in some form or another.

There is a means to automatically, electronically initiate credit checks without fear of lowering the consumer credit score from simply requesting credit history. No, not talking about website navigation. These checks are known as "soft" credit checks and the electronic transaction is known as an EDI 155 transaction. Not a very marketable name for a tool, but a very smart tool to use in doing business, especially if the plan is for the business to receive reimbursement for service, or at least make a plan to do so. A solution utilizing this tool makes the means available, but to what end? The solution is **REVENUEXCELERATOR™** and the end is a treated patient working with the healthcare facility to set the most applicable way to pay for the treatment received.

> ***The organization which helps the patient frame the pathway to wellness is the organization to which the patient will show loyalty.***

CELERACARE

Over the last 14 years **CELERACARE Technologies** engineers have successfully implemented complex business process improvements for approximately 1/3rd of all Fortune 100+ Global firms. Some clients have included Coca-Cola, Maersk, and Sara Lee as well as many, many others.

Specializing in Supply Chain and Business Analytics custom solutions, **CELERACARE** has incorporated healthcare software with world-class features and functions by developing solutions in and with hospitals for hospitals. Ultimately delivering a better bottom line, **CELERACARE** is a provider of leading-edge solutions that embrace and enhance process flow engines within hospitals and medical centers for the benefit of hospitals and medical centers.

The **REVENUEXCELERATOR™** solution was initially designed to provide 3 tangible outcomes:

1. **Reduce Claims Denials**
2. **Enable Ability to Effectively and Efficiently Collect Money Owed to the Hospital at Point of Service**
3. **Streamline Business Processes with More Modern Methods**

Since this is a process flow engine, this system is designed to fit any and all medical center's process flows. The solution is integrated with the present HIS system so there is no down time or lost data.

Ultimately, **REVENUEXCELERATOR™** promotes whatever process flow best gets the medical facility paid.