Experian Health

The Importance of Prioritizing Eligibility Verification throughout the Patient Access Process

An Experian Health White Paper

Prioritizing Eligibility Verification

As healthcare provider profit margins continue to be threatened by unprecedented industry changes, it's more important than ever to focus on the details of the revenue cycle—especially eligibility verification.

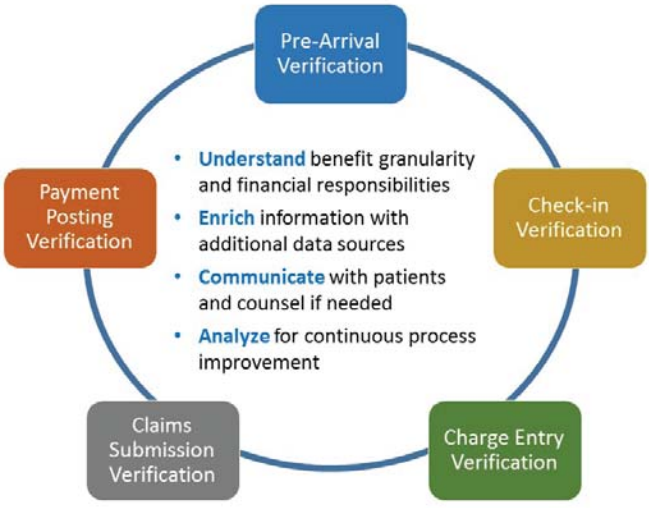
Today's continually changing and increasingly complex healthcare environment requires close attention to validating coverage, benefits, co-payments and deductibles. Failure to prioritize this seemingly small step in the patient access process has huge implications for providers and patients alike:

- Inadequate verification of eligibility and plan-specific benefits puts the healthcare organizations at risk for claim rejections, denials, and bad debt. Ineligible patient insurance coverage is the second most common cause of all claim rejections and denials by payers[1].
- Not understanding coverage and benefit specifics leaves patients financially exposed, fearful and frustrated. In fact, 95% of all patients want a full understanding of coverage and costs involved in a medical procedure[2].

As benefits become more granular and coverage more unpredictable, providers are recognizing the need to take measures—including implementing workflow automation and data optimization—to help them tackle the increasingly intricate eligibility process.

By approaching eligibility verification right from the start, and managing it closely on a continuous basis, providers have the opportunity to reduce financial risk, increase revenue, improve patient relationships, and streamline staff workflow.

Continuous process of eligibility verification



Then...

Ten years ago, eligibility verification was a relatively inconsequential administrative task. Patients presented their insurance card, a copy was made and the assumption was coverage was good for the next 12 months.

- **Providers** counted on a card's validity, and for insurers to pay the majority of the cost of care.
- **Patients**, with little financial responsibility and minimal understanding of costs involved, had confidence that care was covered.

Now...

With the advent of the Affordable Care Act, and subsequent high deductible health plans, patients are able to stop/start/change coverage according to their health and financial situation, meaning the card presented or the existing patient record isn't always an accurate indication of coverage.

- **Providers** risk not getting paid and incurring additional downstream collection expense unless they're able to definitively determine date-specific eligibility and benefit levels.
- **Patients** may be confused about their coverage and, without the right information, surprised by their level of financial responsibility.

6 ways to maximize eligibility verification

The need to reduce healthcare expenses is driving employers to opt for new health plans as often as every year, and individuals to switch plans frequently. The trend has put hospitals and health systems at risk, and requires new and innovative ways to adapt: Never before has accurate, efficient eligibility and benefits verification been so important to the financial health of healthcare organizations.

Providers adopting best practices (see below) that prioritize validation of patient co-pay, benefits and deductible information at all points throughout the billing process are realizing significant advantages. They're experiencing fewer claim rejections and denials and have a new-found ability to provide patient financial counseling programs that help ensure payment while maintaining positive provider/patient relationships.

Prioritizing Eligibility Verification

	By employing these best practices …	*providers can …*	*and patients can …*
1.	**Assure electronic access to eligibility information from virtually all U.S. carriers.** Establish connections with the more than 800 payers that cover 99% of all insured patients, and ensure you have an ongoing process as the market continues to evolve.	Maximize ability to verify coverage within your existing workflow, standardize process, provide price transparency to patients and reduce bad debt.	Arrive at the appointment informed, and ready to meet their financial obligations or receive financial counseling.
2.	**Enrich payer data with additional information.** Collect valuable information not available in the original payer response such as information from payer websites, COB databases and locally stored data to enhance the usability of the response.	Get a comprehensive picture of available benefits, avoid additional manual research and better manage risk.	Avoid the payment mis-understandings that impact relationships with providers.
3.	**Employ automated quality control techniques.** Detect and repair incorrect plan code classification and update the coverage record in the patient's account.	Save time and effort and avoid downstream plan-based issues.	Be assured their coverage records are accurate, complete.
4.	**Automate coordination of benefits (COB).** Proactively address instances where patients are covered by more than one plan and determine primary and secondary status.	Reduce errors and expense caused by manual processes.	Avoid post-encounter confusion and inconvenience.

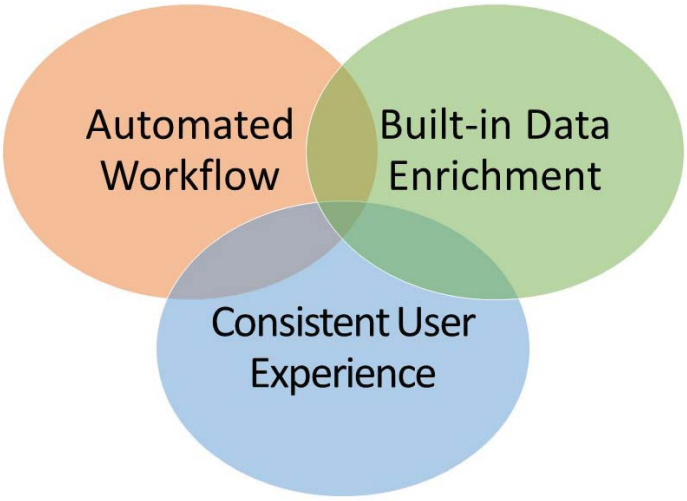
5.	**Enable personalized and normalized presentation of payer response data.** Incorporate the ability for each department and/or end-user to create streamlined benefit views that complement their work styles and focus on the key information for their specific tasks.	Increase clarity, efficiency and productivity among patient access staff.	Streamline time spent in registration process.
6.	**Incorporate ability to report results.** Give patient access management insight into effectiveness of eligibility verification workflows, productivity and results.	Proactively identify and address workflow issues that adversely affect payments.	Benefit from continuous improvement efforts of the patient access team.

Eligibility = Opportunity

Eligibility and benefit verification presents the greatest opportunity to eliminate costs permanently and could save healthcare providers $3 each per transaction[3]

What does it take to prioritize eligibility verification?

Following are key criteria for achieving the expertise needed to quickly, accurately, consistently and frequently verify patient eligibility, and directly impact the success of a provider organization.



Automated Workflow. Automated eligibility verification eliminates ambiguity that may be present in a payer's EDI; reliance on sticky note reminders; and other errors associated with manual data collection. With an emphasis on exception-based intervention, sophisticated automated eligibility verification tools minimize the need for end-user intervention and ad-hoc decision-making. Instead, the patient access team easily obtains information that allows for comprehensive understanding of the intricacies of each patient's benefit plan, and assures benefits are applied correctly.

Built-in Data Enrichment. Relying only on payer information is a short-sighted approach to effective eligibility verification. Without the ability to automatically augment the original standard payer response with critical information extracted from multiple sources, patient eligibility processes can't be optimized. Users are either executing additional manual processes to fill in the data holes, or making decisions without the complete picture. Data from web enrichment, additional non-payer sources, and data translations to user-friendly message segments provides significantly more detail, and adds the value that delivers maximum benefit.

Consistent User Experience. The ability to normalize and modify results so benefit information is consistently represented across all payers makes it easier to interpret by users. A consistent user experience enables faster adoption, high levels of usability—and better results.

Conclusion

Prioritizing eligibility verification from the start—and throughout the patient access process—is imperative in today's in-flux coverage environment. Taking the steps needed to keep up with changes is essential to providers' continued ability to succeed.

Sources

1 "The patient isn't eligible for services because his or her health plan coverage ended, and the patient hasn't shown proof of new insurance." Source: Medical Economics

2 "Almost all patients (95 percent) say it's important to know the total cost of a medical procedure up front, according to a national survey of 407 patients." Source: HFMA

3 CAQH U.S. Healthcare Efficiency Index May 5, 2014