

Point-of-Service Collections in Healthcare

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 PRINT

CASE STUDY

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In recent years, insurance companies have increasingly required patients to absorb a greater share of the financial responsibility for healthcare treatment. Increases in co-pays, coinsurance and deductibles cause a parallel increase in risk to the medical practice (surgery centers, clinics, hospitals, etc.). Point-of-service (POS) collections, defined as the collection of the portion of the bill that is likely the responsibility of the patient prior to the provision of service, is one strategy medical practices may use to counter these trends. This case study will examine options that Arapahoe Gastroenterology considered to collect all fees at the point of service, and the implementation of the selected solution.

Risk Factors

When evaluating this situation, several key risk factors were discussed, including the impact on patient satisfaction, and perception of the primary care physician (PCP) community; inaccurate estimates and costs associated with increased refunds; the staff time necessary to learn and implement a new system; and the financial impact on the practice, including the potential investment in new software to assist with this process, as well as the potential for patients not to proceed with treatment if up-front payment becomes an obstacle.

Patient satisfaction and perception of the PCP community was a significant concern. Limited research has been done on this subject due to the relative newness of point-of-service collections in the healthcare industry. In speaking with pioneers in the field, it was noticed that collection at the POS pushes complaints away from the collection department and toward the front desk. However, the groups currently using this tool feel that patient satisfaction overall has improved in their organizations. This improvement is thought to be due largely to patients receiving education on the front end and feeling empowered to make informed decisions.

Another concern for the practice was inaccurate estimates and costs associated with increased refunds. We at Arapahoe Gastroenterology decided that any solution must prove to be at least 95 percent accurate before we would launch it. This would limit exposure to these increased costs. Incremental costs for each refund was anticipated to be around \$8, including staff costs, materials and postage. Therefore, for every 100 patients treated, the practice may experience an increase in cost of approximately \$40.

Arapahoe Gastroenterology had just implemented new practice management and electronic medical record (EMR) software, so the staff time necessary to learn and implement another new system was also a concern. The staff was sensitized to change, and any additional software implementations had to be quick and easy. After some analysis, training time was anticipated to require a total of 24 hours. These hours would be divided among nine full-time employees representing preauthorization, scheduling and reception. With an average hourly wage of \$14 per hour, training costs would total \$336.

The final two considerations were the financial impact on the practice (including the investment in new software to assist with this process), as well as the potential for patients to decide against the procedure if required to pay in advance. Patients choosing not to have a procedure for financial reasons were of

significant concern due to the high percentage of “screening” procedures that are performed in the group’s facilities. With no way to predict this outcome accurately, the group decided to pay close attention to the number of related cancellations following implementation of the POS collection system, with subsequent adjustments as necessary.

Data Gathering

The clinic’s chief executive officer began the data-gathering process by contacting colleagues to discuss solutions they currently employed to address POS collections. Arapahoe Gastroenterology conducted a literature search (including a review of standard healthcare and practice management publications), as well as participation in frequent discussions on the Medical Group Management Association (MGMA) forum. After a review of this information, it became clear that practices were following one of two basic options: The first was an attempt to develop a proprietary system using existing practice management functionality, Excel spreadsheets and Word documents. The second approach was to find a vendor selling software designed to accomplish this task.

It became clear in the early stages of the data-gathering process that the bulk of the benefit would be derived from application to patients who visit the group’s ambulatory surgery center. Consequently, we evaluated POS collections for those patients first. As outlined in Figure 1: ROI Calculator, (for all figures associated with this article, go to www.surgicenteronline.com) the following conservative assumptions were made, including but not limited to: \$10 million in annual net patient revenue; 80 percent managed-care population; estimated total patient responsibility at 30 percent; and anticipation that the practice will be successful in collecting money at the point of service 50 percent of the time. If these assumptions hold true and this revenue is invested at a 3 percent rate of return, this change should result in additional monthly cash flow of \$4,036.

Historic patient-satisfaction data was difficult to gather, with very few medical practices currently attempting to collect 100 percent of the patient responsibility portion in advance. Without measurable data available, the practice performed a subjective review of those currently employing POS collections. One impression of those surveyed was that the implementation of POS collections resulted in improved patient satisfaction due to education of the patient regarding expectations of their bill. This improvement in patient satisfaction was thought to be derived primarily by eliminating the typical patient experience, where they receive a bill 30 days to 90 days after the date of service, and are “shocked and surprised” by the amount due. Another impression conveyed by those surveyed was that complaints were not reduced but were moved from the collection department to the scheduling department.

Alternatives Considered

After information from multiple sources was collected and discussed, the group felt it had three basic options: continue collecting only part of the patient responsibility portion; develop a proprietary system using existing practice management functionality, Microsoft Excel spreadsheets and Word documents; or find a vendor selling software designed to accomplish this task.

Decision-making and Implementation

The group agreed that market changes resulting in increased patient responsibility were not likely to reverse; therefore, continuing to operate without change would result in a substantial negative financial impact for the group’s cash flow. Since 2003, the practice had seen increases in its patient responsibility portion of no less than 15 percent per year. If this trend continues or even levels off to some degree, the return on investment calculated in Figure 1: ROI Calculator would only improve.

The group briefly discussed using a proprietary approach, but a previous unsatisfactory experience with a proprietary practice management system made this a short-lived discussion. Although some proprietary systems save money in the short run, it was this group’s experience that the amount of time required to debug home-grown systems far outweighs the added cost of a system from an external vendor. In addition, finding an external vendor for this software leverages the experience of multiple practices, which would provide a critical resource for implementation and ongoing improvement ideas in a relatively unexplored field. A slight variation of this plan was to encourage our existing practice management software company to incorporate this type of service, but it became clear that any change of this type would be years down the

road.

After interviewing several vendors, and collecting feedback on cost, reputation, timely implementation and response, and flexibility of the tool, a decision was made to focus on the services of one provider, Financial Healthcare Systems (FHS), which ranked highly in each category. This vendor offered a hosted solution as well as a workflow analysis, and a detailed projection of the financial impact of this change. Anticipated start-up costs were less than \$20,000 including staff training and implementation time. The anticipated ongoing cost was \$800 per month including the cost of the software, materials, postage, and staff costs. The practice justified these costs by examining the improvement in monthly cash flow as laid out in Figure 3: Cash Flow Worksheet. With the conservative assumptions discussed above (and detailed in Figure 1: ROI Calculator), the practice anticipated an increase in collections over the first six months equal to \$192,500 and then leveling off to around \$2,500 per month thereafter.

The implementation was as follows:

1. Selection of software vendor
2. Review cost/benefit
3. Work with vendor to review workflow and implementation plan
4. Work with vendor to load contracts
5. Trial run for 60 days, in which each step was followed short of showing the patient the invoice and collecting
6. Sixty-day data was analyzed for accuracy and met 95 percent accuracy goal
7. Trouble-shooting for those contracts that showed consistent problems
8. Go live on day 61

The FHS software package estimates the patient portion at or before the time of service. It combines payer contracts, provider charge master, and patient benefits into meaningful information represented as a patient estimate letter. Currently, patient benefits are obtained via a direct phone call to the payer. The estimate is presented to the patient to educate them about their benefits and how these benefits translate into "real dollar" out-of-pocket expenses.

Lessons Learned

After implementing this solution, the primary lessons learned can be summarized as training and timing. Training was a critical component of the implementation, and unless staff members are properly prepared to address inevitable patient concerns, reservations, and outright refusal to pay, the level of success achieved will be greatly reduced. Timing is a more subjective decision. The practice must decide how quickly to implement this solution, balancing the impact of inaccuracy vs. the opportunity cost of realizing the added revenue earlier. By delaying the implementation during the 60-day trial period, a number of dollars were left on the table. The 60-day trial period did provide adequate time to achieve a 95 percent accuracy rate, which was the predetermined threshold for success.

Recommendations

The outcome of this situation has been largely positive for the group. With the following recommendations, the process may be improved for those considering an implementation of this type:

1. The practice should evaluate market conditions, and significance of co-pay, deductible and coinsurance. If significant, POS collections should be evaluated as one possible solution.
2. Interview multiple vendors with priority on cost, reputation, history of successful/ timely implementation, and flexibility of the tool
3. Have a clear timeline for implementation that is acceptable to the practice, balancing cost of delay vs. the cost of an inaccurate POS tool.
4. Develop a clear and concise policy for exceptions.
5. Implement where costs are justified. Arapahoe Gastroenterology elected to implement in the ambulatory surgery center setting for six months to 12 months before evaluating its use in the office setting.

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